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EFFICACY OF DRUG ABUSE TREATMENT PROGRAMS (Part 1)

HEARING

BEFORE THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

JULY 25, 1989

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(101st Congress)

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HEARING ON EFFICACY OF DRUG ABUSE TREATMENT PROGRAMS

TUESDAY, JULY 25, 1989

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL,
Washington, DC.

The select committee met, pursuant to call, at 10 a.m., in room 2203, Rayburn House Office Building, Hon. Charles B. Rangel (chairman of the select committee) presiding.

Members present: Representatives Frank J. Guarini, Walter E. Fauntroy, William J. Hughes, Solomon P. Ortiz, Joseph E. Brennan, Nita M. Lowey, Lawrence Coughlin, Benjamin A. Gilman, Michael G. Oxley, James M. Inhofe, Wally Herger, Christopher Shays, and Bill Paxon.

Staff present: Edward H. Jurith, staff director; Elliott A. Brown, minority staff director; James Alexander, professional staff; Austin R. Cooper II, professional staff; Rebecca L. Hedlund, finance/administrative officer; Michael J. Kelley, staff counsel; Barbara A. Stolz, professional staff; Robert S. Weiner, press secretary; Jehru S.V. Brown, metropolitan police detail; Donald A. Streater, D.C. health detailee; Richard Baum, minority professional staff; Melanie T. Young, minority professional staff; and Jennifer A. Brophy, staff assistant.

Chairman RANGEL. The Select Committee on Narcotics Abuse and Control will come to order.

We apologize for being late, but the Committee was in Executive Session to discuss our agenda.

Today begins part one of its hearing on the drug abuse treatment programs. As you know, the drug abuse epidemic continues to grow. With rising drug abuse, increased demands for treatment have become critical. The Select Committee has estimated that six to six and a half million Americans are in need of drug abuse treatment. Currently, the number of slots are dramatically inadequate for drug abusers that are seeking that treatment.

Treatment is a very important part of our national strategy. Effective treatment reduces demand for drugs, by rehabilitating and makes certain that a person no longer needs drugs in order to live. There was a time when we thought once an addict, always an addict. Now, we find the therapeutic community can keep people free of drugs, even though I have to admit there's a lot of skepticism as to what is success, how long do these people stay off of drugs.

In 1965, Drs. Vincent Dole and his wife, the late Marie Nyswander, pioneered methadone maintenance. Many of us protested it because we thought methadone to be a more addictive drug than heroin itself. Now methadone has grown to be one of the main modalities in treating addicts. There are those that believe it is the only way to go in treating heroin addicts. There are those who disagree. But one thing is clear and that is treatment works. We are going to have to look into all of the different approaches to treatment and that is one of the purposes for this hearing.

We want to know what are the elements of an effective program? How should treatment programs be structured? What services should be made available to clients? How do we measure success? How do people get into treatment? Should methadone be for life? Should the patient determine when they should get off of methadone? What degree of counseling and other supportive services are necessary for effective treatment? Is education a necessary part of rehabilitation so that people leave treatment with the tools in order to be not only gaining in self-esteem, but able to earn a living? Also, I'm very interested in the weekly Narcotics Anonymous and Alcoholics Anonymous meetings.

Some of us on this Committee truly believe that we can't fight this war on any one battlefield, that we have to really try to reduce the production of drugs in these drug producing countries. It should be a part of our foreign policy that we should let friend and foe alike know that we consider drug production a threat to our national security. We have to protect our borders with Customs, with Coast Guard, with the military, to deter the intrusion into our society of this poison.

But no one can deny that the most important thing is to educate our people. For those people who have fallen victim to drugs, to be able to have them rehabilitated.

We do not know what we are doing right now in this area. It is all left up to local and state. We do not know what the federal strategy is. We do not know what research is going on. We do not know what direction and leadership is being given to the community hospitals and state agencies that have assumed this responsibility. We commit ourselves on this Committee that we may not find the answers to these serious questions, but we darn sure are going to try.

Mr. Oxley will be representing the minority in connection with the opening statement.

[Opening statement of Chairman Rangel appears on p. 43.]

Chairman RANGEL. Mike.

Mr. OXLEY. Thank you, Mr. Chairman.

First of all, let me commend you for these series of hearings that the Committee has undertaken. I suspect when we saw the article in U.S.A. Today yesterday which indicated that the average taxpayer is willing to pay at least $50 a year more to fight the war on drugs, all of us were encouraged.

But at the same time, I think if you look at the areas that this committee has looked into, clearly treatment and rehabilitation are perhaps the least understood, and the most difficult areas to really sell to the American public. When they think of fighting the war on drugs, they think of interdiction, they think of eradication, they

think of jails and law enforcement, deterrence and so forth. Probably the last thing that comes to mind for most people is the concept of rehabilitation and treatment.

That's the toughest sell, it seems to me, and that's why this hearing and tomorrow's hopefully will bring out some new ideas that we can present to the public and make them understand that while we do want to emphasize education and we do want to emphasize eradication and interdiction and strong law enforcement and locking up felons and so forth, and we want to zero in on user accountability, that it is important that we recognize that there are those people out there who have made a terrible mistake, who at one point perhaps recognized that through the help of their families or their classmates or whatever it may be. They want to make a sincere effort at being rehabilitated.

It seems to me our function at that point is to provide that kind of rehabilitation for them, even though it's not as politically sexy perhaps as some of the other issues that I've enunciated.

That's why I'm looking forward to this kind of opportunity for us to learn a bit more about what works and what doesn't. What we can do not only in the urban areas like your own, Mr. Chairman, but in rural areas like mine as well, where we do deal with numbers of people who have become addicted to drugs of all kinds. How do we deal with those kinds of things? What programs have been successful in other parts of the country that perhaps we don't know about yet? Can we be able to perhaps use the knowledge that we gain from those experimental projects in some cases to make that fit into our respective areas that we represent?

That presents a great challenge for us and that's why I'm pleased that we have these two days of hearings, to bring the Committee up to speed on these programs. I'm looking forward to a very educational two days.

Chairman RANGEL. Thanks, Mike.

Is there any member seeking recognition before we call the witnesses?

We are fortunate today to have professional leaders in this area representing several modalities. We look forward to their testimony.

My friend, Dr. Mitcheli Rosenthal, who operates Phoenix House, a Therapeutic Community and Outpatient drug free program, would you come forward?

Dr. Martin Valdes operates a methadone maintenance program. Where is this program located?

Dr. VALDES. In New York.

Chairman RANGEL. In New York City?

Dr. VALDES. Yes.

Chairman RANGEL. OK, with Dr. Beny Primm. He works with him.

Dr. Joseph Chambers from the District of Columbia area, a private practice psychiatrist specializing in alcoholism and drug addiction.

And very interesting, from Lincoln Hospital, we have Dr. Michael Smith. My sister went to nursing school at Lincoln. He will be sharing with us the results they're getting from acupuncture.

I've also asked one of our professional staffers, Donald Streater, to testify with this group. Donald?

I had a group of young people that came to visit with me as they were trying to seek guidance as to where they should go in terms of career. Donald came into my office yesterday and I asked him whether he would mind talking with the kids for a minute. I asked him how old was he when he graduated from law school.

What did you say?

Mr. STREATER. Forty-eight.

Chairman RANGEL. Forty-eight years old. I asked whether he had a family and what stage in their academic or professional career they were in, and what did you respond?

Mr. STREATER. My oldest daughter is in her second year of law school, my middle daughter is a nutritionist and my youngest daughter just finished touring with Michael Jackson. I have a son 14, I have a son 12.

Chairman RANGEL. And then I asked you in front of these kids, "And what makes your life so unique in showing these accomplishments?"

Mr. STREATER. Mr. Chairman, I was addicted to heroin for 17 years and I've been clean for a little over 13 years.

Chairman RANGEL. Well, we welcome your testimony. Proceed in a manner that you feel most comfortable, Mr. Streater.

TESTIMONY OF DONALD A. STREATER, D.C. HEALTH DETAILEE

Mr. STREATER. Thank you, Mr. Chairman.

Good morning, Mr. Chairman and members of the committee. I am a recovering addict and my name is Donald Streater. My presence here reflects the fact that treatment works and that effective treatment truly rehabilitates.

A little over 13 years ago, I was addicted to heroin, having used everything from cocaine, morphine, dilaudid, even swallowed mace that you use in the kitchen and also nutmeg. I used Dristan inhalers, anything I could use to change my mood. My addiction lasted well over 17 years. I traded my family for drugs. Drugs became my everything, became more important than bathing, more important than anything else. I stole and committed other crimes to support my habit.

I was a treatment bum. I was in and out of all types of various treatment programs. I probably went through every type of modality known. I was probably one of the first group of people on methadone here in Washington, DC. I was on methadone for about 3 years. I've been to psychiatrists, I've been in all types of, as I said, treatment modalities. I finally ended up in the therapeutic community at St. Elizabeths Hospital on November 4, 1975. Since that time, I haven't had any drugs or any mood changing chemicals.

I've been employed for the first time in my life for about 12 years. I'm a single parent. My 14 year old son is with me. I'm a productive member of the community. I asked the Chairman to testify because I wanted to point out that treatment does work.

There's been a lot of focus on the failures, the killings and the rising drug abuse problems. In my opinion, there's not enough focus on the success. There are some programs out there that are

working and they're cost beneficial to society to look at those programs and to expand on the success of the programs that are working for people.

There are thousands of people like myself who are working today and are drug-free. I believe that we should pay attention to them and see how they're structured, how they're set up, what the components are that turns out a person like myself and others who have been as successful as I have.

Thank you.

Chairman RANGEL. Thank you, Mr. Streater. Dr. Rosenthal, I had the occasion to visit with you at your campus in New York and was very impressed.

TESTIMONY OF DR. MITCHELL ROSENTHAL, PRESIDENT, PHOENIX HOUSE FOUNDATION

Dr. ROSENTHAL. Thank you, Mr. Chairman.

First, let me commend you and the Committee for your constant vigil here and also for bringing Don Streater before this group because I share his view that it's essential that people who have made it and who have overcome their worst fears and who have dealt with their innermost problems give us the most hope. It is from them that we learn that addiction is curable, whether it's from Don Streater or whether it's from Julio Martinez, who is the director of New York State's Division of Substance Abuse, who himself was a heroin user, or any of other people who are in leadership or in important roles in New York or in other parts of the United States and other parts of the world who are a real testament to the effectiveness of treatment. With all of the talk about the hopelessness, it's important that this light is turned on this way.

I'd like to point out, first of all, that the goal of drug abuse treatment has got to be a cure. This cure involves substantial abstinence with minimal likelihood of relapse. Plus, changes in the negative attitudes, the values and the behavior, that are as much a part of the drug abuse syndrome as chemical dependency.

Please understand that drug abuse is a disorder that diminishes the ability to function normally. Drug abusers become driven people, self-destructive and out of control. Abuse prompts behavior that is anti-social, often violent, frequently criminal and manifests an almost absolute indifference on the impact on others.

It is responsible for increased crime, the spread of A.I.D.S. and also the rising rates of homelessness, mental illness, teen runaways, adolescent suicide, child abuse and neglect.

Drug-free treatment attacks the basis for drug abuse, the underlying causes that are much the same for all abusers. It enables them to confront and overcome the emotional problems and negative conditioning that prompt and sustain not only drug abuse, but all kinds of anti-social behavior and self-destructive behavior.

Programs that are not drug-free can also help drug abusers recover, and chemical interventions can play a useful role. But what's important to recognize about substitute drugs, drug antagonists and blocking drugs is that they cannot cure drug abuse by themselves. It is not methadone, the drug itself, that cures metha-

done maintenance patients. It is counseling and clinic therapy groups that constitute the true treatment aspects of methadone programs.

But it is difficult for methadone programs to provide the same kind of structure, discipline and support that drug-free programs do. These are exactly what's needed to change addict attitudes and values.

This issue is close to the crux of today's treatment dilemma. My colleagues who operate methadone programs are divided. Many, like Dr. Beny Primm, who is represented by Martin Valdes today, Dr. Herbert Cleber from Yale who is the nominee of Mr. Bennett for the treatment division, believe strongly in the need for structure and discipline. Others maintain that rigidities drive addicts out of treatment. They would eliminate controls. They would reduce or eliminate counseling. They would create clinics with no services for methadone resupply, now euphemistically called "no frills."

What they propose cannot be considered treatment. It will not cure addicts, nor will it, as they contend, reduce crime or reduce the spread of A.I.D.S. Yet there is growing support for greater use of methadone and other chemical interventions, including proposals to develop a methadone-like drug for cocaine and crack, a so-called methadone clone.

Part of this support comes from a perception of drug-free treatment as being not very cost effective. But large scale follow-up studies of the National Institute of Drug Abuse have found methadone maintenance and drug-free residential programs equally successful in reducing heroin use and criminal activity.

Now, the cost of methadone maintenance in New York runs about $3,000 a year per patient. Residential treatment runs close to $15,000 a year per patient. But residential treatment lasts, on average, 18 months or a total cost of $22,500, while methadone maintenance, if successful, is life-long. So, a 25-year-old addict entering a methadone program will, if he succeeds, run up a lifetime tab of $150,000. What's more, sole criterion of success at most methadone centers today is remaining in treatment. So, successful methadone patients may use drugs other than heroin, as about 60 percent of those in New York City now do. They depend on public assistance and may even engage in crime.

A successful outcome for a drug-free patient, however, is based on drug abstinence, employment and no criminal involvement. Studies of former heroin addicts treated at Phoenix House and other therapeutic communities across the United States followed up for 3 years, 5 years and 7 years after they left treatment, found only 5 percent in one group of graduates and none in another had subsequently used opioids. More than half had been arrested in the year preceding treatment and only one percent in the year that followed treatment. Full-time employment rose from an average of 2.2 months a year before treatment to more than 11 months after treatment.

But the bad rap on drug-free residential programs is that we have so few graduates. It's true that dropout rates are high. But what the bad rappers don't say is that dropouts also succeed. For dropouts in the Phoenix House studies and in other therapeutic

communities, opioid use fell from 95 percent to 26 percent, among dropouts. Arrests fell from 63 percent to 15 percent and average months of full-time employment rose from 3½ months to more than 7 months a year.

Success and improvement wasn't related to graduation, but simply to the length of treatment. Best successes with no post-treatment drug use or criminality, plus full-time employment, or truly significant improvement—that might be marred, for example, by no more than one instance of post-treatment drug use—is achieved by about 60 percent of the Phoenix House dropouts who stay in treatment for eight months.

Now, cost-effectiveness is determined not by success rates, but by positive utilization and that's best understood of when dropouts tend to quit treatment. For example, at Phoenix House, half of all our dropouts leave within the first 30 days and most of these during the first 5 days of treatment.

Now, if we forget total admissions for a moment and look at how the dropout rate might affect a 10 bed dormitory at Phoenix House, 8 of those beds would be filled for the full year by 8 young men and women, each of whom would go on to graduate. Two of the beds, however, would be filled over the course of the year by 42 different youngsters who will remain for little more than 2 weeks each. In terms of total admissions, that dorm will have an annual dropout rate of 84 percent, with a success rate of just 16 percent. But at any given moment during the year, the success rate will be 80 percent. At year's end, 80 percent of the treatment capacity of that dorm will have been used positively, for young men and women who will subsequently succeed.

Don't count out the 42 youngsters that left. A number of them will return to treatment. We should be clear that retention is a problem for us, but retention is a problem for all treatment programs and it is most troublesome for those that impose the kind of discipline and behavioral demands that are necessary to produce real cures.

If drug abusers are free to use drugs without fear of arrest or any social sanction, then they will do just that. They will not enter treatment. If they are offered treatment options that make no demands on them, that do not even require them to stop using drugs, then that's what they'll choose. They will not choose to be cured.

What I hope this committee will recognize is that we can no longer afford to leave this decision to drug abusers. We must make that decision. I pray that we have the sense to demand that treatment provide true cures, that we give drug abusers not what they want, but what they need, the chance to reclaim their lives.

Thank you very much.

Chairman RANGEL. Thank you, Dr. Rosenthal.

[Statement of Dr. Rosenthal appears on p. 48.]

Chairman RANGEL. Dr. Valdes is the Associate Director of Medical Service for the Addiction Research and Treatment Corporation.

I'm glad you were able to come and be with us.

TESTIMONY OF DR. MARTIN VALDES, ASSOCIATE DIRECTOR FOR MEDICAL SERVICES, ADDICTION RESEARCH AND TREATMENT CORP.

Dr. VALDES. Thank you, Mr. Chairman.

Mr. Chairman, members of this committee, I want to thank you for inviting me to testify before the Select Committee on Narcotics Abuse and Control. My testimony follows those of Dr. Beny Primm and Dr. Larry Brown in 1985 and 1987, both of whom have been leaders in bringing attention to the ravages of the disease of drug addiction.

Notwithstanding the prevailing financial constraints and saturation of resources for health care delivery in New York City, A.R.T.C. has succeeded in enlarging its provision of community services. And believe me, it's been very difficult at times.

I have carefully reread the statements by Dr. Primm and Dr. Brown to the 99th Congress and the 100th Congress Select Committee. Although some progress has been made since their last appearance here, I find that the litany of problems continues to grow. It weighs heavy on a minority population already oppressed by myriad problems, including discrimination, unemployment, lack of education, stigmatization, crime and on and on. In addition, the drug addict population was already beset by a higher prevalence of many diseases, including tuberculosis, viral hepatitis, sexually transmitted diseases, bacterial endocarditis and other diseases of chronic undernourishment and stress.

But this was already true many years before the advent of the Human Immunodeficiency Virus. Therefore, we should ask what was done to combat these problems. I propose that nothing or very little was done.

The drug addicted are perceived as social deviants, non-compliant, uneducated, angry, destructive, dangerous, untrustworthy and a "they got what they asked for" attitude.

Who lobbies for the drug addicted? They themselves are unable to since their daily activities mostly revolve around survival and providing for their basic needs, which include craving for the opiates. Lobbying is a luxury which they don't have. How can they effectively organize when they are already plagued by the problems I already mentioned?

The drug addicted population has been labeled non-compliant and criminal. So the label sticks regardless of what characteristics are real and which are myth.

I want to point out something that they are subject to that is the so-called Rosenthal effect. What this gentleman did was he took two groups of rats. One group of rats he labeled dumb and one group of rats he labeled smart, gave them to a group of graduate students and told them to put them through a maze. Obviously, none of the dumb rats got through the maze and all of the smart rats got through. Filming of the handling of the rats revealed some interesting things about how the graduate students handled the smart rats versus the dumb rats.

One of the big things that is said against the drug addict, and this applies in the labeling, is that they're non-compliant. We have done a survey in our population in the appointments made versus

appointments kept. We found that 50 percent of our population keeps their appointments. This is roughly similar to the rest of the population.

Let me also provide you with some very worrisome numbers. As of March 2, 1989, 6,450 persons were enrolled or had previously participated in A.I.D.S. clinical trials at one of the sites sponsored by the National Institute of Allergies and Infectious Diseases. Yet only 6.5 percent of the persons were female, 8.5 percent were non-white and 89 percent had never used drugs. This is in great contrast to the representation of these groups in H.I.V. morbidity and mortality.

By February 13, 1989, the Centers for Disease Control had received reports of 86,157 cases of A.I.D.S., with I.V.D.A.s representing 27 percent of the total. Additionally, in New York City, blacks and Hispanics had a higher cumulative incidence of A.I.D.S. cases, higher than any other racial or ethnic group in any other state.

The problems are multitudinous. The onslaught of H.I.V. has made a desperate situation even worse. With lack of resources and very few choices in the struggle, we have to stand back and strengthen what is at our disposal. A comprehensive approach to drug addiction is the best weapon we have. But a prerequisite to this course must be the placing of the addictions unequivocally within the medical model. It is a disease entity with a psychophysiopathology, with an etiology or etiologies, with a mechanism of occurrence. It is capable of being studied at the basic science level and at the epidemiological level.

Furthermore, one of its manifestations, heroin addiction, has a medication for treatment, methadone. Unfortunately, this therapeutic agent has been fraught with misunderstanding, clouded by moral pronouncements evaluated by people that lack the expertise or experience to reach objective conclusions. Curiously, this is part of the overall irrational approach to drug addiction. Witness the misconceptions so rampant about methadone, such as you're trading one drug for another or it is not a cure. Well, antihypertensives are not a cure, insulin is not a cure, most antineoplastic agents do not cure but rather provide a period of remission. Somehow we do not give up on these modalities or attach a stigma to their use.

These misconceptions ignore the not insignificant number of patients who, while on methadone, are employed and lead productive families lives. There is mounting evidence that patients stabilized on methadone maintenance show a significant rise in employment. Any system has non-compliance. Nonetheless, we don't indict the diabetic when he cheats on his diet or the hypertensive who cheats on his salt intake or forgets to take his medication. On the contrary, we reinforce, counsel, find alternative incentives for better compliance.

The treatment of drug addiction must be comprehensive. It must include general education, counseling, both social and psychological, group therapy, medical intervention, outreach efforts, teaching basic life skills, job counseling, prevention, child care services, primary care services. The education must be directed to the substance abuser and the community at large. All of this must take place in a climate free of myth and political agendas.

The commitment to drug addiction must change drastically. Dr. Beny Primm has proposed a supermarket approach to the problem whereby the treatment is specifically geared to the individual patient's needs. He or she is welcomed into a comprehensive treatment center. There, he or she or even their family, receives those modalities of treatment best suited to the individual, whether acupuncture, drug-free status with mild counseling, primary care services, et cetera.

Some patients will benefit from accelerated reentry into the mainstream, while some patients will require life-long treatment. This is not unique to addiction, but holds true for most medical diseases.

Dr. Marie Nyswander, in her "Drug Addiction in the United States: Past and Present," has described the lot of the drug addict most eloquently. "Drug addiction is a distinct medical entity which ravages the patient, destroys the entire fabric of his life, and adversely affects the lives of his family and others close to him.

"As in every major disease, the patient is helpless before its destructive inroads. Struggle as he may, the curious and inexorable process overwhelms him, no outer moral compulsion can stay it, no authoritarian decree can cut it short. Punishment is meaningless, imprisonment futile in halting the relentless course of the disease."

If we expect and prepare for relapses and complications in every other disease, why should we demand more of the drug addicted?

Anecdotally, I would like to add that in our clinics we have each patient carry an I.D. When the patient dies, those I.D.'s are given to me. The I.D.'s on my desk are beginning to pile very high from these young people dying from A.I.D.S. It's extremely urgent that we tackle this issue with some vigor.

Thank you.

Chairman RANGEL. Thank you, Dr. Valdes.

[Statement of Dr. Valdes appears on p. 61.]

Chairman RANGEL. The Committee will recess for 10 minutes as we go to vote on the Carl Amendment to the D.O.D. bill that's on the floor and we'll be back on time.

[Whereupon, at 11 a.m., the select committee recessed until 11:16 a.m.]

Chairman RANGEL. We apologize for the recess.

Now we'll hear from a doctor from the area who specializes in alcoholism and drug addiction, Dr. Joseph Chambers.

We thank you for taking time out to share your views with us.

TESTIMONY OF DR. JOSEPH CHAMBERS, PSYCHIATRIST, ADDICTIONOLOGIST

Dr. CHAMBERS. Thank you, Mr. Chairman. Thank you for the opportunity to share my experiences and ideas with the Committee.

I've been in the business here a long time. My focus today will be to talk briefly about the role of self-help organizations in the treatment of addictive disorders.

We look at a nation and we see alcoholism through one pair of glasses and we see smoking crack through quite a different pair. And yet in many respects, this is the same illness. We are, perhaps, more friendly and open to the fact that someone who has some

lace of substance in the community is in trouble with alcohol. We re more supportive of this individual because alcohol is legal.

Unfortunately, drugs don't know, nor do they care, whether hey're legal or not. They go on about the business of producing ad- liction and whether that addiction is a legal alcohol addiction or is n addiction to smoking cocaine and destroying everything within matter of a few months, the addiction is the addiction.

What then works? Prior to 1935 and the advent of Alcoholics Anonymous, we really had very little in the way of hope for people. With the development of this organization, there have been world- wide over two million recoveries, with well over a million recover- es in the United States and Canada. So, we find Alcoholics Anony- mous and alcohol addiction and treatment centers and recovery as very acceptable modes in our society. People generally support them and they receive a lot of help.

Not too many years ago, alcohol was illegal and we repealed that. Most of us who are older, believe that alcohol is OK. Also in our society, we have the idea that drinking beer really isn't drink- ing. The problem with all of this is that when we go to talking about addicts and we talk about drugs, we don't have people who use one drug anymore. Oh, they're scattered around. A few people are thoroughbreds and just drink alcohol and a few people just do heroin and a few people just do cocaine. Most people today, at least our younger people, smoke marijuana, snort or smoke cocaine and drink beer. We have multi-addictions. This is very true in our cities.

In our cities, the problem is compounded by the fact that people start using drugs and alcohol at a very young age, in the early years in school, people of 6, 8, and 10 years of age. Our P.C.P. prob- lems here in Washington had to do with children of 8 and 10 years of age using P.C.P.

So, what are we dealing with in terms of people that are involved in our problems? We're dealing with people who haven't gone through adolescence. We're dealing with the immaturity, the impa- tience and the impulsiveness of people who really haven't had much of a shot at even their early school years. We're talking about people who have been deprived of 10 or 15 years of the proc- ess of growing up, by societal conditions, but also more particularly by the use of alcohol and drugs.

What does work for these people? When somebody comes in to see us, the first thing they may need are some warm clothes and something to eat. We see our problems with alcohol and drugs and broken families and lost jobs. We see our homeless populations con- tinuing to escalate. We have massive social issues to treat. We are not treating the alcoholism of a suburban GS-10 gentleman who works for one of the federal agencies. We're treating at a very more basic and deeper level of difficulty, the problems we're facing with drugs, particularly in our cities.

Yet where do most of the people get well? Many of the people get well within their churches. Ten or 15 percent of them make some sort of a conversion and a commitment to their church and they go on down the road and through this they are helped to recover and heal.

For most, that doesn't work. What happens with most drug addicts? What do we do? Most of my practice is in suburban Montgomery County. My patients have many resources now in Washington, we see an entirely different kind of drug problem from the problem that I saw years ago at DC General Hospital.

Many of the people that I have the privilege to work with come from the cities and they come out and they go through a treatment center which will cost, with detoxification, $8,000 or $10,000. Then, with these people who are coming out on their own and have the families that can help them, then we have a recovery rate with our drug addicts of about 30 percent. That's a wonderful recovery rate for cancer. That's a splendid recovery rate for heart disease.

So, in a sense, under ideal circumstances, these people can do very well indeed.

We have in the area many, many Narcotics Anonymous groups, full of people who are on the streets, as Mr. Streater indicated to us. People are able to get well in groups. People are able to get well in recovery programs. The majority of people who are staying in recovery, and I'm not talking just about inner city problems, I'm talking in terms of the problem of addiction around the country, are in the support systems of Narcotics Anonymous, Cocaine Anonymous and Alcoholics Anonymous. By now, these 12 step programs really mix one into the other because many people are candidates for all of the particular programs.

I would like to see what can Congress do to help us. I would like to see some sort of basic on-street; support, shelter and counseling and direction for people.

Thank you.

Chairman RANGEL. Thank you, Doctor.

[Statement of Dr. Chambers appears on p. 67.]

Chairman RANGEL. I want to thank staff for certainly bringing a diversified view in terms of how we should approach this problem. Certainly Dr. Michael Smith from Lincoln Hospital—my sister went to nursing school there—specializes in acupuncture. Staff has been greatly impressed with the visit they had to Lincoln.

So, I am anxious to hear your views, Dr. Smith.

TESTIMONY OF DR. MICHAEL O. SMITH, MEDICAL DIRECTOR, SUBSTANCE ABUSE DIVISION, LINCOLN HOSPITAL

Dr. SMITH. Thank you very much. We're very close to your district and we're certainly involved with the problems that all of us face.

I'm the Medical Director of the Substance Abuse Division, Department of Psychiatry at Lincoln Hospital. It's an honor to speak before Congress about our work. We are indeed fortunate to be able to use the many thousand year tradition of acupuncture for the benefit of many of New York's most under served citizens.

I am a physician, a psychiatrist who has learned acupuncture on the job in the South Bronx. I used to work for a methadone program, and for a therapeutic community. I remember being initially skeptical that such an apparently delicate process such as acupuncture could have a real impact on drug addiction. However, 15 years

large-scale clinical experience has persuaded many of us of the pularity and the effectiveness of acupuncture treatment.

Each day we see 250 clients in our clinic. The program consists of ople sitting in a large community room with very short needles the outside of their ears. They appear to be relaxing and medi-ing. Our program involves counseling, Narcotics Anonymous, ine contracting, we take urines on a daily basis.

It's important to clarify that acupuncture is only a foundation long-term psychosocial recovery. It is not a replacement for unseling. It is not a replacement for residential programs or Nar-tics Anonymous. It is best used as a component with these pro-ams.

Acupuncture controls withdrawal symptoms for many drugs, con-ls craving. It also reduces fears and hostilities that usually dis-rb the drug abuse treatment setting. Acupuncture has a balanc-g effect on the autonomic and neurotransmitter systems.

The location of ear points that we use and the technique of inser-n can be taught easily so that most acupuncture components can staffed by a wide range of substance abuse clinicians. In fact, a was passed by the state legislature in New York last year ving that acupuncture may be conducted in state approved drug d alcohol programs and therefore would be exempt from normal ensing, provided proper training and supervision takes place.

I think most of the recognition we've had recently is due to the rge number of crack patients seen daily in our clinic. We have d 8,000 crack patients treated at Lincoln in the past three years. ır program has had the highest success ever recorded in the eatment of unscreened, court referred populations seen on an tpatient basis. More than 50 percent of these clients provide neg-ve urines for at least the 2 months following referral and we see arly 1,500 court referred clients a year, which is far more than ner programs see.

In a preliminary study with the Police Foundation, we have ced the outcomes a year and a half later of 34 clients referred to ncoln by New York City Probation Department. The statistics e detailed, but let me summarize by saying that frequent attend-ce at Lincoln, that is more than 10 visits, correlated with a five one improvement in outcome for this series of clients. The ople who did not attend our program were arrested five times as en as the people who did attend the program.

In April 1987, I was invited to Portland, OR. Later, the county ted to allow $60,000 of Federal Bureau of Justice funds to create new acupuncture components in existing programs. For in-nce, their inpatient detox program previously had been mainly alcohol detox that catered nearly exclusively to white clientele cause presumably other people didn't want to come to the pro-am.

The program was changed a great deal in that heroin, cocaine d methamphetamine patients began to come in large numbers. e retention rate went from 34 percent up to 85 percent in this it over a 6 month period of time.

An independent evaluation done in Portland, OR stated, "In con-usion, acupuncture appears to be a very cost effective modality in pplementing and supportive comprehensive detox treatment pro-

grams. It also provides an adjunct treatment that can be applied during the entire cycle of detoxification."

One of the worst symptoms of the crack epidemic has been the massive increase in maternal substance abuse and the consequent retention of cocaine-positive infants in hospitals as boarder babies. Many of these infants are deprived of love and nurturing until their mothers are able to receive successful drug abuse treatment or very limited foster care is located.

As virtually the only available outpatient program focusing on crack abuse in the city, Lincoln Hospital has received more than 3,000 referrals of drug abusing mothers in the past 30 months. We are pleased to report that our program appears to have saved the city more than $3 million just in 1987 by reducing costs of boarder babies and subsequent foster care of infants that were seen at Lincoln Hospital.

Only a program which directly helps young women become drug free will have a substantial effect on the rate of H.I.V. positive findings in mothers and children within the context of New York City. These women can then involve their partners in treatment.

Let me give you an example. One of our patients told me that her husband had walked with her to the clinic with a baseball bat in case she did anything wrong. Looking out my window, I could see a man in the parking lot holding a bat. Two weeks later, this patient waved me over and said, "This is my husband. He doesn't have a drug problem, but he's kind of nervous. Can you help him?"

Now, the patient made a big accomplishment in getting a guy with a bat to walk in the door and sit down for treatment. He couldn't admit what his problem was. Maybe he would not respond that well to treatment, but one of the main advantages of our acupuncture program is we can involve virtually unreachable, often psychotic people in treatment.

The best retention rate in our clinic is by our social worker who sees mentally ill chemical abusers. Unusually troubled people relate to this kind of open access treatment because their needs are so great. You have to really start at the beginning before they can adapt to conventional treatment.

We are frequently asked about the reaction of the medical/scientific community to our use of acupuncture. There are several placebo studies. Let me cite the most recent one, which was done by Dr. Milton Bullock and Patricia Culliton. This was conducted in Hennepin County in Minneapolis, using the protocol that we use with chronic, extremely heavily relapsing alcoholics. This is a study that was published in the British medical journal Lancet, June 24, 1989.

They took people who had at least 10 hospitalizations in the past year and said, "Fine, we're going to give you free room and board, with no counseling treatment permitted. We're going to give half of you what we consider accurate acupuncture points, half of you what we consider sham points, but still points on the ear." The randomized group that had the treatment points, 21 out of 40 completed the 2 month program. The group that had the sham points, only one out of 40 completed the program.

You don't get this kind of ratio on a placebo study for any kind drug except something like penicillin. This is a very wide differ-

ce. It was the second successful placebo study that they had pub-
hed.

They did 6 months follow-up and even without counseling and
y other supportive treatment, there was a significant difference
outcome results. Now, we believe in counseling and treatment,
t when the scientists get to work, they often eliminate things
ey can't follow as precisely.

There has been a study mostly completed at University of Cali-
rnia at San Francisco, looking at heroin patients, again using
is placebo protocol. Currently, there is a N.D.R.I. study being
nded by N.I.D.A. conducted at Lincoln looking at crack patients.
'e've been asked to participate in research study treating babies
Beth Israel. In this case, primarily babies addicted to methadone
ve been selected.

I've always supported the position that acupuncture can be only
component, part of the whole process of drug abuse treatment.
early all of the existing acupuncture drug abuse programs were
veloped within existing licensed treatment programs. Lincoln
ospital acupuncture program has received a great deal of nation-
and international attention. More than 60 clinics in the United
tates and another 25 in Europe and Latin America and Asia, have
en established explicitly on the model of our clinic in the South
ronx. Indeed, Lincoln Hospital has become a mecca for visitors
nd journalists of all sorts.

The National Acupuncture Detox Association, or N.A.D.A., was
unded in 1985 by clinicians who wanted to extend the example of
e Lincoln Hospital experience into other treatment settings.
.A.D.A. has conducted many training programs for public institu-
ons and communities in under developed areas, both here and
broad, and in more conventional treatment settings as well. It has
t standards for certification for acupuncture detoxification spe-
alists that are widely accepted in the substance abuse field.

Sometimes when you talk about something like acupuncture that
itially sounds so unusual, one or two props are helpful. If they
re, they are available. I brought some of the needles. It's easy to
e what a simple process this is. We take daily urines. I don't
now of any other program that does that. The N.I.D.A. people said
e have really the best database that they've ever seen in the drug
buse field. We do that partly because we want to follow people for
riminal justice and partly because we want to allay any skepti-
ism and we want to be very clear what we can accomplish and
hat we need help accomplishing.

Thank you very much for your attention.

Chairman RANGEL. Thank you, Dr. Smith.

[Statement of Dr. Smith appears on p. 68.]

Chairman RANGEL. Well, this panel has certainly proven or shat-
ered the myth that treatment doesn't work. All of you are pretty
onvinced that the area of treatment that you're giving is effective.

You mentioned something, N.A.D.A. What group is that?

Dr. SMITH. Well, it's our professional organization—I'm the
hairman of the group and we use the word N.A.D.A. with its
panish connotation as well, meaning no nonsense, direct drug-free
pproach. The full name is National Acupuncture Detoxification
ssociation. We have observer status with the United Nations.

Chairman RANGEL. Now, do all of you belong to similars types of national groups that deal with your particular modality? I mean when professionals are doing something, do you attend any meetings to see whether they have new techniques or new modalities or different things?

What I'm really trying to get at is what role does my government play in sharing with you what we are supposed to know?

Dr. SMITH. Since the microphone is near me, I think lately it's been a very minimal role. We do certainly attend meetings with each other quite frequently. When you work in the South Bronx, you often work on your own. I frankly don't expect a great deal of help. When it comes, that's good. But we teach our clients to be self-reliant and we have to be self-reliant as well.

Chairman RANGEL. Dr. Rosenthal.

Dr. ROSENTHAL. Well, there are a number of forums for therapeutic communities. There is a national group called Therapeutic Communities of America which has 300 or more members across the United States, programs like Phoenix House, Daytop Village, Samaritan Halfway Society, Gateway in Chicago, the Marathon Group in New England, Amity in Arizona—and we have a vote coming up.

Chairman RANGEL. Well, how does Health and Human Services fit into what you do on a——

Dr. ROSENTHAL. Well, N.I.D.A. has, over many years, provided assistance first of all for research. Many of the studies that I quoted here today and many other studies are studies that have been funded by N.I.D.A. So, the data that we have in this field, some of it better than others, has been, in large measure, aided by government research grants.

N.I.D.A. has also taken a role in bringing about meetings, professional meetings of substance abuse workers in different areas and I think they have a decent record in this area.

Chairman RANGEL. Could any of you define for me what you believe the federal policy is in treating drug abusers? I don't know what it is, so I'm asking. You're the professionals. The closest I've heard to it is what Dr. Valdes said, a supermarket approach, do your own thing and we'll try to get some money out there.

Dr. ROSENTHAL. I think in recent years the federal government's role has been one of passing down to the states in the block grant support and then leaving the state governments to decide where they want to invest those dollars. There hasn't been any template that's been established by the federal government that says, "These are the kinds of programs we support and these are the kinds of programs that we don't support."

Chairman RANGEL. Well, that means that the 50 states and the possessions each have their own policies, but we don't have a Federal policy.

Dr. ROSENTHAL. That is correct. There are some general Federal guidelines. There are general federal guidelines about confidentiality, there are federal regulations concerning how methadone is distributed. But in terms of a strategy for a particular state or a region, the Federal Government is not articulating the strategy.

Chairman RANGEL. Dr. Valdes.

Dr. VALDES. I think the bottomline is that there has been no olicy or at least it's been irrational so far. You can see that in me of the guidelines each department has in dealing with drug buse. For example, drug abuse is not under the Department of ealth in New York. It's under the Department of Substance buse.

What I want to emphasize though is that this is a population at already had a lot of problems before the present inquiry. They ad a lot of primary care problems and what was being done about is? Nothing, absolutely nothing. It's only recently that .H.R.S.A. has undertaken a primary care initiative to tackle some the issues that this population had. Why did we wait so long?

Chairman RANGEL. Dr. Valdes, that's a rhetorical question. You now because you answered, it was a politically powerless commuity and there was very little concern about it. But now that the idemic has spread and the Congress is in an uproar and the oney is being authorized and appropriated, I want to find out w that money is being used. Where could we really put more dolrs? What is really working?

I'm really looking for my Secretary of Health and Human Servs to have some type of a network out there where you profesonals can tune in so that we can find out what is available, what ould be made available and where are the rip-offs. You know, e've got Medicaid doctors out there that should be in jail. We an't depend on the American Medical Association. They open up poor communities where people are sick and without clothes and ithout food and without shelter and they just give them these rescriptive drugs. It's pitiful how they're being ripped off.

As Streater said, he was a modality bum. He would go wherever omeone was going to treat him nice or treat him like a human eing.

I'm not saying these things are bad, but we ought to be able to now where we can get the maximum best return based on the ype of problems that the patient has and what works and what oesn't.

Dr. Smith and then Dr. Chambers.

Dr. SMITH. You know, in 1987, we began to see this huge change ith crack. That meant that a great number of crack dealers earned a new career and were flexible enough to do things differntly. We in the treatment field, however, have not been as flexible s the drug dealers. We are less healthy for being less flexible than he drug dealers. When you are less healthy then drug dealers, you re in deep, deep trouble.

Chairman RANGEL. Well, we're going to try to get the Secretary f Health and Human Services to try and pull all of this together. Not that we've got to mandate what you should be doing, but at east that we'll have a better idea as to nationally what's available o that we can be of more help to states and to local governments.

Dr. Chambers.

Dr. CHAMBERS. Over the course of the last ten years, there's the American Medical Society on Addictive Medicine. This certifies physicians as addictionologists. They now have a membership of about 6,000 or 7,000 physicians in the country, about 2,500 of whom are certified as experts in addictionology. This is a real resource in

terms of where to go and what to do. Their headquarters are in New York City. They may be under their old name. They changed to a simpler name. It was the American Medical Society on Alcoholism and Other Drug Dependencies and they kind of consolidated that into A.M.S.A.M.

Chairman RANGEL. I hope you work with staff so that we can hook up with them because, quite frankly, I don't think that this administration has any ideas, any plans, any strategy or any policy. But I dc sincerely believe that they're going to try to get these things together. They can't do it unless they have the expertise that you have developed over the years. So, we hope that you stick with your government just a little longer. I truly believe help is on the way.

With that, I call on minority leadership, Mr. Coughlin.

Mr. COUGHLIN. Mr. Chairman, can we go vote and come back? The second bell has rung.

Chairman RANGEL. Yes, we'll do that. We'll recess another 10 minutes.

I hope that during the time I'm gone that you would reflect on each other's testimony and see whether or not you would have any observations to make. I don't know whether Doctor Rosenthal thinks that there's any need for methadone at all, but still I may be wrong. But we'll talk about that when we get back.

[Whereupon, at 11:47 a.m., the select committee recessed until 12:04 p.m.]

Chairman RANGEL. The Committee will resume and the Chair recognizes Larry Coughlin.

Mr. COUGHLIN. Thank you, Mr. Chairman.

As you've indicated, and as the Secretary of Health & Human Services has indicated to the Chairman and myself, one of the primary functions that the federal government has is to fund so-called treatment slots by sending money back to the states in the form of block grants. As we listen to the panel here it appears there is no consensus as to how we should define a slot. There are various different approaches being discussed by the panel.

My question is—should the Federal Government be involved in trying to define a slot or a modality? Should the Federal Government fund a particular type of treatment program, or do we not yet know which programs work and which do not? In your opinion, what kind of approach should we take?

Dr. SMITH. I think the slot is a different thing for different types of modalities, first of all. But it's important—the way the federal government works the situation, the way the state government works is you have different consumer treatment groups asking for something and asking to continue what they are doing. They have very little room for flexibility.

Government has to provide an umbrella for flexibility so that when new populations are in trouble, such as there are so many women with small children who are now starting to use drugs. That group has done very poorly in conventional drug programs. So, since everyone in the field is going to ask for a repeat of the same funding, there is going to be no room for new approaches reaching these other people. And if you say, "Fine, you have your thousand slots. We fund your thousand slots again," that almost

forbids flexibility and it forbids looking at new patient populations, not just at modalities.

First you look at the patient population, who do you want to reach? You have to say, "Well, fine, we're going to give you the same money as the thousand slots, but we want 200 of those slots to gradually go this way or we want to do it differently," and that takes an overall plan. Otherwise the women who use crack and it may be 40, 50 percent of all crack users in New York are women, this is the major vector for A.I.D.S. in New York City, those women have almost no treatment at all. They have almost no possibility for treatment because of their different population needs. Without a plan, without a government plan, they will continue to have no treatment into the next century.

Mr. COUGHLIN. Do you have any recommendations for Drug Czar Bennett as to what a federal treatment plan should be?

Dr. VALDES. I would like to clarify, and this will partly answer your question, the supermarket approach that Dr. Beny Primm has meant. The analogy is the same as when you walk into a supermarket and you get what you need, that should be the model for a treatment center. That is, the treatment should be individualized so that the spectrum of treatments may range from a patient just going for counseling to a patient being on methadone for the rest of their lives while gainfully employed and leading productive lives.

The government has to be involved in this, has to be an integral part in the recognition that treatment must be comprehensive and the slots that are created must include that type of flexibility to deal with each patient.

Dr. ROSENTHAL. Mr. Coughlin, I don't think that in thinking about a strategy for Mr. Bennett that we can just talk about a treatment strategy without the context of a broader national strategy.

Mr. COUGHLIN. But I'm trying to address the question of a treatment strategy—the treatment component of the strategy.

Dr. ROSENTHAL. I understand that, but if, for instance, we don't have effective law enforcement, then it's going to make an enormous difference on the demand for treatment and on the thinking about treatment. If addicts in New York learned tomorrow that the mayor, the governor and everyone else in town was really serious about demanding treatment, we would have lines around the block of Phoenix House that would look like Ticketron when they were giving away tickets for My Fair Lady.

The fact that in most parts of the United States people can take drugs and use drugs with relative immunity effects significantly what the treatment strategy is going to be because addicts don't come into treatment, for the most part, because they wake up one morning and say, "Gee, I hate who I have become. I don't like the fact that I am lying to my parents, I'm lying to my spouse," or, "Mom, I'm failing in school. I'm taking drugs. I've been stealing from you and Dad. Would you please take me for treatment?"

Treatment strategy has to be in the context of a society that is making a no drugs demand. Just like a family has to make a no drugs demand on its child, a society has to make a no drugs demand on its members. Then, in that context, we have to have availability of treatment and have a variety of modalities with an

understanding that most people can be cured, that addiction is a curable illness and that there are a number of different routes to get there.

Mr. COUGHLIN. Thank you, Mr. Chairman.

Chairman RANGEL. Mr. Hughes.

Mr. HUGHES. Well, thank you very much. I certainly have learned a lot today about the sort of individualized experimental nature of what we're doing. I have some concern that we're not doing what we need to be doing to see that what is working in some areas is shared in other areas. That's unfortunate. It's almost like an extension service is needed to look at what's happening in various parts of the country and saying to others, "Look, this is working here. That's something we think you ought to take a look at." It seems to me that that would be a very important role for the federal government.

I have a few questions that bear upon the types of drugs. Do I take it that the modality of treatment will vary from drug to drug? For instance, crack is the most recent drug of choice for some users. I would presume that that would present a special problem, unlike, for instance, heroin which is something we've dealt with for a long time. Crack is a relatively recent phenomenon. We treat patients differently?

Dr. ROSENTHAL. We have been treating crack addicts at Phoenix House for the last four years, both adults and adolescents. I would say that the modality and the treatment strategy is essentially unchanged and that the kind of effectiveness that we have had with heroin addicts or poly-drug users or angel dust users is the same.

But this reflects an underlying philosophy that drug abuse is a symptom of underlying problems and that what we're treating is not the specific symptoms of any one drug but we're treating a whole person in trying to have that person come to understand how he or she handles a variety of life problems and stressful problems and can handle those without needing any kind of chemical means.

You know, there's been a lot of talk here this morning about the point you made, Mr. Hughes, that the government should play more of a role in expanding information and having everybody know what's working and what isn't working. I think that that's true, but it doesn't address, I think, a much more startling problem that the city of Los Angeles has 93 beds for kids 13 to 18 who need long-term treatment, that New York State has less than 500 beds for kids 13 to 20 that need treatment and that if you go to other parts of this country, there is almost nothing existent for a parent who is not a working parent and doesn't have insurance that's going to pay for a 28 day wonder cure.

So, I think we have enough information about the predictability and effectiveness of a large number of treatments that are simply not being supported with very good evidence about their effectiveness.

Mr. COUGHLIN. Let me ask you a question. About what percentage of the population requires residential treatment as opposed to outpatient treatment? Is this something that's determined depending on the type of drug?

Dr. ROSENTHAL. That's a terrific question and very difficult to nswer. It is generally not determined by the drug as much as by e dysfunction and by doing a total assessment of either an adoscent or an adult. How long has the drug use been going on? hat is the frequency, what's the dosage and how dysfunctional as that person become with family and school, on the job? We ways try and treat that person at home and within the communi- before residential treatment and use residential treatment as e last resort not the first resort.

Mr. COUGHLIN. But even with residential beds, I would assume at they still require intensive follow-up supervision for a period time including urinalysis if there are offenders that have been ferred to a detoxification or treatment center. I understand that ven outpatient care is severely lacking, particularly in the larger ties.

Dr. Rosenthal, I was just bringing up—I agree with you. I was st bringing up one glaring example of a deficiency in the system. think that we certainly have insufficient outpatient programs. A arent with a 15, 16 or 17 year old kid that is abusing drugs, delinuent and truant from school faces a nightmare of trying to find he right treatment for that kid. Do we have any formal training r counselors for chemical dependency? Do we have facilities that ctually train drug counselors?

Dr. ROSENTHAL. Yes, we do. I think that it varies from state to tate. Probably more states are not doing something about this han are. But there is, I think, across the country, a general movenent toward training and toward certification.

Mr. COUGHLIN. Can you give me some idea, as to how widespread tate certification is of counselors?

Dr. ROSENTHAL. There is no certification. There are some people n the audience who are going to testify later today who could robably answer that.

Mr. COUGHLIN. All right. We'll get to that, subject with a subsequent panel. Well, thank you. I see that we have another vote.

Chairman RANGEL. Ms. Lowey.

Ms. LOWEY. Thank you, Mr. Chairman.

It's a pleasure to hear your testimony and I'm particularly deighted to hear from Dr. Rosenthal. I've had the pleasure, and shall I say privilege, of touring Phoenix House and it's extraordinary. In fact, the Chairman and I were talking as we walked back here that we wish that some of those youngsters could have that opportunity without being addicted to drugs because I think it is certainly such an outstanding environment.

I have several questions, but because time is short, I'm particularly interested in the intake process. We've talked about the fact that there's a long waiting list and we need more Phoenix Houses. Do you tend to accept youngsters with the greatest chance of success or as one of your criteria do you tend to accept youngsters with the greatest degree of trouble? I just wonder what makes you select one rather than another since the line is around the corner.

Dr. ROSENTHAL. We'll take both, but the kid who is in the most trouble, the kid who might be homeless, who might be living in Grand Central Station, who is in severe trouble or who is really out

of control and who's in danger, we'll try and reach out and make a bed for that kid, even if there is a waiting list.

Ms. LOWEY. The reason I ask that, of course, is that I think in evaluating your success figures, which are phenomenal, it's good to know whether your youngsters are preselected. So, you're not necessarily selecting those that would have the greatest degree of success?

Dr. ROSENTHAL. Not at all.

Ms. LOWEY. Another question I wonder about. Perhaps we can continue another time.

Dr. ROSENTHAL. Very quickly though, if you were to take 100 youngsters that came in to us and do a psychological assessment and then say who were the healthiest, who were the sickest of those kids, we would tend to—the sickest kids would tend to leave sooner. That is, their disorder would also make it sometimes more difficult to treat them.

Ms. LOWEY. Another question which perhaps we can talk about another time or perhaps you can submit ideas to this committee. We're particularly interested in education. What can we do in our schools and our elementary schools, junior highs and high schools so we don't get youngsters to that point? And I wonder from your counseling programs what lessons you could offer to us, what help you could give us, advice you can give us so that we can establish better programs in our elementary schools? And then, of course, we have to fund them and hope we will be able to find the funds to do so.

So, if there are any quick observations you can share with us, perhaps we can pursue it.

Dr. ROSENTHAL. Without taking a lot of time here, I think there are very smart strategies for kids for elementary schools. There is a total lack of uniformity across states, school districts, even within certain school districts and it's a whole subject in and of itself. You're quite right about the funds.

Ms. LOWEY. But do you feel that if we focused on additional funds for programs of education in our elementary schools, perhaps we would limit the number of youngsters that come to you later on?

Dr. ROSENTHAL. Yes, and there's a big payoff in this. I mean the fact that over ten years, from 1979 to last year, we see a drop in the number of high school seniors who are getting loaded on marijuana every single day go down from 13 percent to three percent last year is a very remarkable finding. I think it says that we are getting a payoff from efforts we're making in prevention and education.

Ms. LOWEY. Thank you.

Chairman RANGEL. Mr. Gilman.

Mr. GILMAN. Thank you, Mr. Chairman. I see we're on the second bell. I just have one major question.

As we try to make recommendations to Mr. Bennett on his new strategy, what would you recommend? I know there's differences in modality and what's better for the drug addict in each different area and each age group differs, but what would you generally recommend? I address it to the whole panel. You only have about a

nute because we're going to run. What would you recommend to
r. Bennett?

Dr. SMITH. I would recommend that you tie treatment to the iminal justice system and you emphasize outpatient treatment in e early stage so that you're not clogging the criminal justice stem. It helps both sides——

Mr. GILMAN. Make it a condition, in other words?

Dr. SMITH. And if you design it correctly, we've worked with ousands of these people. We've set up programs in other cities. It very possible——

Mr. GILMAN. Mandatory treatment is part of their sentencing.

Dr. SMITH. What you want is not mandatory treatment——

Mr. GILMAN. I'd like to hear some of the others. Any other one ant to comment on that?

Dr. CHAMBERS. I'd just like to second what Dr. Smith said.

Dr. VALDES. Money has to be allocated to basic research. It has to e allocated to the clinical aspect of treatment and has to be allo- ated to enforcement. I'm very skeptical and I suspect that a lot of he money is going to go to enforcement, it's not going to go to the ther two.

Mr. GILMAN. But what about for treatment? What are you re- uesting?

Dr. VALDES. Well, for example, for heroin we have methadone lus counseling plus a number of other things.

Mr. GILMAN. Research for some chemical——

Dr. VALDES. For cocaine, we don't have the equivalent. Let's do ome research on that.

Mr. GILMAN. Dr. Rosenthal.

Dr. ROSENTHAL. Well, we need a four-fold increase in treatment unds. We need to institutionalize the training mechanisms and we eed to be very ambitious about what we do with the criminal jus- ice system. Seventy percent of people who we are holding in our risons have drug abuse histories and we're basically not doing nything in the 3 to 5 years that they're with us to change their ife-long drug patterns.

Mr. GILMAN. Any other panelists? Mr. Streater.

Mr. STREATER. I think that when you have the youngsters who re arrested, like the pretrial diversion system, if you have some- thing like that where you could treat those youngsters, have a place rather than putting them in jails, I think that——

Mr. GILMAN. That's what Dr. Smith is suggesting, conditioning this sentencing on some sort of mandatory——

Mr. STREATER. But I think it's different than compulsory treat- ment.

Mr. GILMAN. You'd make it voluntary?

Mr. STREATER. Yes.

Mr. GILMAN. Thank you. I'm sorry, gentleman, but we're on a roll call.

Chairman RANGEL. Can everyone stay until we get back? Do you have time problems? Go ahead back. Let the committee go.

I just want to ask you, do you think we can—what's this vote on? I'll stay.

I visited your Phoenix House. As I've told you, you treat people like decent human beings with a positive view that they can be

helped. I don't know whether you're really dealing with anything that deals with drugs. You give a decent place for a kid to live. You give friends, you give counseling, you give love, you give affection, you give self-esteem, you giving training, you give education and you give less reasons why people would be dependent on chemicals. Why would you need methadone with what you're providing in this supermarket?

I understood you, Dr. Valdes. Why would that be on the shelves?

Dr. ROSENTHAL. Well, the unit that you saw was a unit that primarily treats kids 14 to 20. I'd certainly not want to see any methadone used with that age group.

Chairman RANGEL. I think Dr. Valdes would differ with you and maybe Mr. Streater.

Dr. ROSENTHAL. I don't think Dr. Primm would want to see—Dr. Primm's been doing this for as long as I have. I don't think Dr. Primm would want to see methadone used——

Chairman RANGEL. Who is that doctor in New York, the lady? Mary Jane Creek. She wants to see that methadone there. She wants that methadone there and she wants it there for life. She's not taking any nonsense from your no drug people.

Dr. ROSENTHAL. Well, Mary Jane Creek is a woman of strong opinions, but most of us in this field have strong opinions. I think there is more shared opinion about adolescents and the fact that we certainly ought to give adolescents a chance to be treated without any chemical interventions. Then the argument starts when we have young adults and people in their 20's who have a 3-year, 5-year history of addiction.

Chairman RANGEL. I don't know whether I get that approach from my no frills methadone clinics that I have at 125th Street. They're saying, "You come in here, we've got some methadone for you." Now, I know that Dr. Primm doesn't support the no frill and he thinks there should be supportive services and counseling and all of that. But there are people, not at this table, that are pushing methadone out there for anybody in that age group or not.

Right, Dr. Valdes?

Dr. VALDES. Well, in this particular age group, unfortunately I haven't had the experience with this group to be able to make a statement. I suspect that there may be some individuals that may benefit. By and large, I tend to agree with Dr. Rosenthal in regards to this age group. But we must individualize drug treatment as we do in any other disease.

Chairman RANGEL. I'm saying why. You say that there's some of us that have mischaracterized methadone and we've said it's just another substitute for drugs and it's one addiction for another. Okay. I've seen what he's doing. Unlike some other places that just tell people to sing hymns and feel good about themselves. I don't know what really happens after they graduate or leave that treatment.

But I'm saying, Doctor, if you had every resource available to you, you've been exposed to all these modalities and all the different ways, if someone just told you, "But you're out of methadone and you're going to be without it for three or four years," would that be the end of your treatment center really? Would you have to substitute other types of things for that?

Dr. VALDES. I think that would be unfair because——

Chairman RANGEL. I know. It's not going to happen because it's too cheap and it's in the minority communities. The powerful medical institutions are supporting it as well as the pharmaceuticals. So, believe me, you have no fear that methadone is going to come off the shelves.

I'm merely asking that if Dr. Smith came with those needles and was able to convince you that methadone is not going to be here, but as relates to withdrawal pains and all those things that methadone is supposed to relieve, it would be unfair, but could you go on doing good and rehabilitating people?

Dr. VALDES. We don't understand the addictions enough. Would you do that to a diabetic? Would you deny a diabetic the insulin? Would you deny——

Chairman RANGEL. I'm mean and I'm unfair, Dr. Valdes.

Dr. ROSENTHAL. I might. Eighty percent of diabetics can be treated with diet and encouraging them to diet properly and they don't need insulin. I always think that the insulin analogy is——

Dr. VALDES. There is my answer. In fact, some diabetics may benefit from no insulin. Some drug addicts may be drug free. But there is a significant percent that will require methadone either short term or for life.

Chairman RANGEL. I think Dr. Smith said it. If that's your business and that's all you know and the game in town is getting these darn things funded—and I've got a secretary that says he's funding slots. I said, "What modality?" He said slots. He's got some slots. You want slots? He's got slots. I don't know. I need to find out. What is he selling? What is the federal government encouraging?

If they had an attitude that we were going to get away from methadone, and that's not going to happen, I would want to know, what are you going to substitute it with? What's going to be nearly as effective as that? Does a person have to be on methadone all of their lives in order to be productive? I don't know. I really don't know. But I would like to try as many different ways that makes people less dependent on chemicals as possible.

Now, I don't know whether you've seen Phoenix House.

Dr. VALDES. I haven't, no.

Chairman RANGEL. Well, if I had a kid that wasn't on drugs, I would want to send him to Phoenix House anyway because it creates a climate and environment of self-esteem and education. These kids really leave there full of a whole lot of enthusiasm. They've got kids, brothers and sisters, that want to join the program that are not on drugs.

To me, in order to deal with this problem, we're going to have to deal with shelter, we're going to have to deal with education, job opportunities. I don't care how good you are. If you kick those kids out with a couple of bucks in their pocket and they can't read, they can't write, they can't do anything and their families have rejected them, I don't see where the treatment is going to be long-lasting.

Dr. VALDES. I agree with you. That the approach to drug addition has to include confronting the social ills you've just mentioned.

Chairman RANGEL. But my point was that if you find hospitals that are doing well because of the methadone clinics and doctors that are retired but are coming back because they need some doc-

tors there, if you find the best written programs done by institutions that are really good institutions that are involved in methadone, I think that you don't have really the flexibility that Dr. Primm and you would like to see in terms of alternatives.

I truly believe that the reason I pick on methadone is because they're so powerful and nobody takes them on. I want to keep challenging them. I want to know why a kid has to dedicate himself to methadone for the rest of his life in order to succeed. I don't know whether you know my doctor friend or not, but I'm not putting you on. What's her name?

Dr. VALDES. Mary Jane Creek.

Chairman RANGEL. Do you know Mary Jane Creek?

Dr. VALDES. Yes.

Chairman RANGEL. Am I putting you on? She says you have to stay on this because if you don't, you've got to go back——

Dr. VALDES. Well, you may have to stay. We don't like to see kids on insulin. We don't like to see kids on medications. Ideally, nobody should be on anything. We should have a magic pill that we give everyone and we cure them. Unfortunately, we don't.

Chairman RANGEL. Well, listen, I don't know why you are being so defensive about this. Methadone is not in any problem of being wiped out, you know. I'm just trying to see whether or not you'd be willing to try some acupuncture at your place.

Dr. VALDES. Oh, absolutely. In fact, I already said it. Yes.

Chairman RANGEL. Are there any slots over at your place for acupuncture?

Dr. VALDES. We welcome anything, anything and everything that will benefit the patient and enhances their dignity.

Chairman RANGEL. You welcome, but there's no one fighting for that.

Dr. VALDES. Where is the money to do all of this? We get paid a set amount per capita per day per visit, no matter what we do, no matter how much primary care we provide.

Chairman RANGEL. I think you're making my point, Doc. Would you think that you would have to be cost effective in terms of how many people you serve with the limited dollars that are available?

Dr. VALDES. We are very cost effective. In fact, we sometimes defy the laws of physics. We create from nothing.

Chairman RANGEL. Dr. Rosenthal is saying that treatment is not cost effective in how many people you can see in a short period of time. It's how many people would probably not need any drugs or any supervision or any infusion of federal or local or state dollars. That's what he is saying. I'm afraid that if I were running a clinic and I wanted to impress Julio Martinez, I would say, "Heck, I'm seeing more people than he's seeing. I'm running them through my methadone clinic. I see 100 a day. They don't see anybody but me, but they leave okay."

So, I don't think the flexibility is there because you are dealing with cost effectiveness. You're dealing with the dollar. I wish I was dealing with a panel everyday that was dealing with the treatment. I don't know whether it's cost effective if that person has to see you the rest of their life. I don't mean you, Dr. Valdes. I mean some of that lady's patients.

So, I hope all of you would draft a paper directed to Dr. Bennett that I can assure you he's going to read. But I don't know what effect it's going to have. Or maybe better still to Secretary Sullivan in saying that you are willing to sit around a table, to fight with each other, to argue with each other, to say what you truly believe works for you with your clientele.

I guess there's a place for methadone because I'm not going to go against the medical industry as to what they believe is effective. All I'm saying is that if there are opportunities, as you pointed out, Dr. Valdes, to give people who are talking about rehabilitation without dependency, give that a chance too, have that flexibility.

Dr. Smith, do you go beyond drug substance in terms of acupuncture at Lincoln Hospital?

Dr. SMITH. How do you mean go beyond? You mean treating people who are not yet addicted or who are simply stressed out?

Chairman RANGEL. No, I'm talking about surgery and other ailments.

Dr. SMITH. We certainly do. In fact, we treat a lot of A.I.D.S. patients using acupuncture. We treat asthma, all sorts of things.

Chairman RANGEL. And are there any legal problems in doctors practicing acupuncture in New York State?

Dr. SMITH. Medical doctors need, at this point, 300 hours of training so that they can be certified. Licensing laws for private practice acupuncture need to be changed. But in the drug abuse field, we got a law so that the drug abuse field is exempt from the acupuncture licensing laws, provided it's done with the cooperation of the state agency. So, the legal problems are no longer there for this field.

Chairman RANGEL. This panel has been tremendously helpful. We're just scratching the surface. We have an administration who has a lot to learn. I'm hopeful that they're going to be receptive to these ideas.

The question in having a policy, Dr. Rosenthal, that my colleagues have been begging for is so that they can see how treatment is only one aspect of it. We hope if Bill Bennett really looks at the whole thing, that he would be talking about law enforcement, housing, education, preventive treatment, job training. We really believe that what you're doing in Phoenix House is substituting the bad lifestyles that some of my kids are forced to live with. You're removing the peer pressure, you're removing the alcoholic mother, you're removing the abusive father, you're removing a bum educational system. You are giving them something to live for. I don't know whether we can do that for every kid that comes from a poor community or a broken family. I really don't know. But I'm not going to allow people just to give that kid a pill.

Dr. CHAMBERS. Amen. We need to talk about character restructuring. With these patients that we have, it's part of where they're coming from. But tremendously devastated by their drugs is their personalities as people who have become responsible and concerned about the needs of other people and concerned about their own behavior.

In the kind of program that Dr. Rosenthal is getting underway, these are the same principles that are used in the self-help organi-

zations of learning how to clean house and help other people and get your values back together.

Chairman RANGEL. Well, Mr. Streater really has emphasized to me the importance of those self-help organizations.

Nita, over the weekend, I met a gentleman in my community. He's a black Republican. We don't have too many of those. But he has two daughters that were addicted to drugs. One of them got cured, according to him, by going back to Jesus. You indicated that a small percentage, but still a significant number of people have found the church as a method of shaking off this habit. I wonder why we don't find more churches and synagogues more actively involved in this. Obviously it's all a part of the same thing. Yet I don't really see the church involved to the same extent.

I would ask the doctors, all of you are doctors, is this abandonment of offspring, is this something new? I watch these television programs and see how attentive the animals are to their offspring. I just never heard of mothers abandoning their children. I'm not talking about morally, just physically. How do you do these things? I've seen mothers die for children, but not abandon.

Dr. VALDES. In fact, I don't think this is new. In the old days they used to kill children, especially girls. So, we're——

Chairman RANGEL. It's not new?

Dr. VALDES. I don't think it's new, no.

Chairman RANGEL. OK. I don't know.

Nita?

Ms. LOWEY. Well, I just had one comment. I apologize because I had to go back and vote.

Chairman RANGEL. I didn't. I'm senior.

Ms. LOWEY. I think when we're talking about abandoning our children, I think one of my problems with the eviction from the public housing projects, is that it appears to me that so many of these parents are helpless. It's not that they've abandoned their child, they just don't know what to do with this child. That's why your program is so outstanding.

Dr. ROSENTHAL. There are certainly many parents, maybe even most parents, that are facing a drug abusing child across this country who are helpless with a kid out of control and don't know where to go and there are terribly limited resources.

I think what Congressman Rangel was saying about mothers abandoning their children is, in fact, happening. I think it's a right observation. I think that what Dr. Chambers was saying about character deterioration with drug use, I think the young mothers who are using and who are out of control are abandoning children. If we look at the 14, 15 year olds who are in Phoenix House, many of those kids have drug abusing parents. It is a significant part of this equation.

You hear about all of these technologies and which one should we go with and where should we back it, there is information about this. It needs to be refined and improved, but overall we have a tremendous amount of technology and ability in this country to cure addiction in different ways. What we don't have is a national commitment to come forward and sustain the kinds of resources and funds that are needed.

Here we are in 1989 right now with all of the talk about this and a place like Phoenix House, I don't know about my colleagues here, is facing an absolutely flat budget with no increases in funds. We'll get a little money for—a little waiting list money, but it is really a pittance when we're talking about the——

Ms. LOWEY. Well, there's no doubt and I hear this not only from you but, of course, as you know we have Renaissance in our community and we have Daytop and we're paying more to workers at McDonald's than we are to some of those workers at Renaissance House. This has been a major, major problem.

Dr. ROSENTHAL. Yes, and you have a first-rate program like Renaissance in your community and yet they have to go to Sullivan County, outside of Westchester County, in order to have a place because the community in Westchester has basically made it so difficult for them to have a place there. This is another problem that we face all across the country where everybody says, "It's terrific work."

Ms. LOWEY. "Not in my backyard."

Dr. ROSENTHAL. Right.

Ms. LOWEY. But I think that's clearly one of the problems and we have to address it. But even if we had the place, according to Joe Cleary and others, they don't have enough money to fund the program they have in place right now.

Dr. ROSENTHAL. Oh, they don't. They're struggling.

Ms. LOWEY. So, hopefully, with our Chairman's outstanding work, we can deliver that message and that the government can take a very strong position and make it very clear that this is a top priority. It's more important than anything else.

I was delighted to be able to sponsor an amendment with our chairman to turn the military bases that are going to be closed into drug rehab centers and prisons so that at least we can perhaps make it a top priority that we have additional facilities.

Dr. ROSENTHAL. It's a terrific idea, to have military bases that are turned into villages for kids and adults that are drug-free and that offer promise and comprehensive services.

Ms. LOWEY. Thank you.

Chairman RANGEL. I think our bill stands a good chance of being incorporated in D.O.D.

Ms. LOWEY. Exactly.

Chairman RANGEL. Well, listen, this has been a great panel and I hope that I can bring you together perhaps in an informal way for you to share your ideas with some of the people in the Administration.

We are awaiting the report from Mr. Bennett. Clearly, treatment is going to be in there. Even if we disagree with him, we're confident there will be avenues for us to communicate. I hope that we all may be in agreement. Maybe it would be so broad and expansive.

Thank you very much. You've made a great contribution. I'll be visiting Lincoln with my sister.

[Whereupon, at 12:47 p.m., the select committee recessed until 1:10 p.m.]

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Ms. LOWEY. Thank you very much. I understand we have a vote, so we'll begin with Mr. Koehler. We are delighted to hear his testimony.

Welcome.

TESTIMONY OF RICHARD KOEHLER, COMMISSIONER, NEW YORK CITY DEPARTMENT OF CORRECTION

Mr. KOEHLER. Good morning, and thank you for inviting me to meet with you today.

My name is Richard Koehler and I am the Commissioner of the New York City Department of Correction. I am also the Chairman of the Legislative Committee of the American Jail Association.

I've been asked to talk to you this morning about one of, if not the most serious challenges facing my Department, our city, and the nation. We are inundated in New York and in cities and counties across the country with huge increases in the jail population and with corresponding increases in the numbers of individuals who come to us with substance abuse problems. I've been asked to and will discuss the correctional aspects of this problem.

However, let me be clear on one thing from the outset. While I believe that developing and implementing correctional strategies to deal with drug dependent inmates is terribly important, such programs do little to solve the crisis. We must, as a nation, attack this problem by focusing on our children. Otherwise, the problems of the next generation will make us look back on today as the good old days.

My presentation today will be based on our experience in coping with the drug crisis as it affects the population in the jails. The New York City Department of Correction has developed and implemented innovative programs to respond to the need of drug abusers. We are proud of our efforts, and today I would like to share with you a few things: first, the detailed description of the substance abuse problem in the New York City jails; then an outline of the initiatives we have taken; then my views on the steps that must be taken in the future to deal more aggressively with the drug abuse problem.

Before I outline our initiatives, I think it is important to understand some basic facts concerning the New York City Department of Correction. We have responsibility for the administration of 17 jails. Today, as usual, these facilities are operating at over 100 percent of capacity, with almost 19,000 individuals in our custody.

Our jails are distinct from prisons in several important ways. We experience rapid turnover. Over 100,000 individuals will be admitted to our custody each year, with an average length of stay of only 39 days. Over 65 percent of the inmates in the New York City system are pretrial or presentence detainees, people waiting for trial. The individuals remanded to our custody have many programming needs. In addition to their substance abuse problems, which I will outline in detail in a moment, several other important facts are critical to understanding the problem of dealing with our inmate population.

First, 60 percent of those admitted to our custody read below the fourth grade level. Ninety percent of all inmates have dropped out

of school by grade 10. Ten percent of those in our custody speak a primary language other than English. Eighty-three percent of all inmates are unemployed at arrest and lack job readiness skills.

The Department has experienced tremendous growth in recent years, with the inmate population having grown almost 20 percent from this time last year. Certainly, the substance abuse epidemic is growing at equally extraordinary rates, striding through our communities and overwhelming the criminal justice systems and jurisdictions all across the country. In New York, we are seeing the consequences among the inmates in our facilities, as indicated by the following statistics: 85 percent of the inmates surveyed in March, 1989, report using drugs at least once a week prior to their arrest; 39 percent of the inmates surveyed in March, 1989, report use of more than one drug prior to arrest; and 74 percent of the individuals given urine tests in Manhattan Central booking in March, 1988 tested positive for cocaine.

Over 18,000 inmates receive methadone detoxification each year in the New York City Department of Correction.

The City Department of Health estimates that 50 percent of the inmate population has a history of I.V. drug use, and therefore 20 to 25 percent of the inmate population is H.I.V.-positive.

These figures, coupled with information reported anecdotally, indicate that the inmates in New York City are plagued by substance abuse problems which have often led to their incarceration. Moreover, inmates' addiction problems have contributed to the deterioration of their family life, their health, their ability to obtain and sustain employment, and their entire way of life.

By the time inmates with substance abuse problems reach jail, they are truly individuals in crisis. The entry of this crisis population into jail is a critical point in trying to begin to assist them to recognize their drug abuse problems. We have found that inmates are more responsive to intervention soon after their incarceration. They tend to be somewhat introspective, and they are cognizant of the consequences of their lifestyle. Experts also agree that individuals who successfully complete 30 to 60 days of pretreatment are more likely to continue long-term treatment.

I believe that the New York City Department of Correction has responded to the drug abuse crisis with positive and creative initiatives that are sensitive to these concerns. I am also encouraged by other efforts being made around the country. The American Jail Association has three model projects that have good potential. These projects are funded by the United States Department of Justice. One is in Cook County, IL. One is in Pima County, AZ. And one is in Hillsborough County, FL. We are carefully monitoring these programs to evaluate their impact.

Several substance abuse programs have been implemented or expanded within the New York City facilities with the encouragement and support of Mayor Edward I. Koch since I became Commissioner in September, 1986. Two of these initiatives are operated in conjunction with the New York State Division of Substance Abuse Services. These programs are in addition to the Methadone Detoxification Program which serves 18,000 inmates a year.

In March 1987, a methadone maintenance program was implemented. This program guarantees participation in community-

based methadone programs upon release of inmates. Over 2,000 men and women participate in this program each year, and 72 percent of those discharged have reported to community-based programs.

In October 1987, a 50-bed drug-free therapeutic program, Promesa, was implemented to provide services for adolescent inmates. Over 650 inmates have entered the program, and 60 individuals discharged were placed in community-based treatment as an alternative to their incarceration.

In addition to these programs, we are very proud of our substance abuse services which are provided to inmates through independent organizations and vendors, including regular Alcoholics Anonymous and Narcotics Anonymous.

Ms. LOWEY. Excuse me, Mr. Koehler. We were just wondering if it's possible, because we're concerned that there will be several votes, one following the other——

Mr. KOEHLER. Yes.

Ms. LOWEY [continuing]. Whether we could ask you to summarize. And perhaps what we can do is ask each of the other panelists to summarize in about 5 minutes each so we'll have time for an effective interchange and ask you some questions. Is that possible?

Mr. KOEHLER. Fine. Certainly.

Ms. LOWEY. And then, of course, your statement will be included in the record.

Mr. KOEHLER. Sure.

Ms. LOWEY. Thank you so much.

Mr. KOEHLER. I think that the critical elements of my statement are, first of all, we have a very serious problem. Second of all, it's very late when you ask the criminal justice system, jails and police, to deal with the problem.

I think that we've tried some things in New York City. We'll have 1,100 drug treatment beds. We'll have a floating jail, which will be a drug treatment facility. But I view these things all in the context of a holding action.

There really needs to be a national plan that begins to focus on children, focuses on the educational problems that we have, focuses on the employment problems that we have, focuses on the homeless issues, and doesn't ask a correction administrator who gets a person who's 25 years old, arrested seven times, addicted to drugs, can't read, and has never had a job, to fix the problem. We're really focusing in the wrong place.

And that's essentially my testimony, with some recommendations for how you can have jails do their holding action a little better than they do. So there are concrete recommendations here, but this is the wrong place to begin to solve the problem.

Ms. LOWEY. Thank you very much, Mr. Koehler.

[Statement of Mr. Koehler appears on p. 87.]

Ms. LOWEY. Mr. Gustafson.

TESTIMONY OF JOHN GUSTAFSON, DEPUTY DIRECTOR, D.S.A.S., NEW YORK STATE

Mr. GUSTAFSON. Thank you.

My name is John Gustafson. I am a Deputy Director with the New York State Division of Substance Abuse Services. I am appearing before you today as the President of N.A.S.A.D.A.D., the National Association of State Alcohol and Drug Abuse Directors. This is an association that represents the single state agencies for drug and alcohol services throughout the country.

The publicly funded alcohol and other drug prevention and treatment system has relied heavily upon federal leadership and financial support over the past two decades. Under the previous Administration, however, with the passage of the A.D.M.S. Block Grant in 1981, the system of services suffered a drastic reduction in federal support. We believe this has contributed significantly to the crisis we all recognize exists today.

In fiscal year 1980, Federal appropriations for alcohol and drug abuse programs totalled $322 million. In 1981, funding was reduced to $262 million, and in fiscal year 1982 to $225 million. In fact, it was not until 1987, with the passage of the A.D.T.R. Block Grant, that any Federal increases were appropriated. Federal support for New York State's program, by way of example, actually decreased by more than 39 percent from 1980 to 1982. Furthermore, New York State has suffered a cumulative loss of nearly $66 million in that period of time.

By contrast, New York has consistently supported with increased state dollars significant additional programs. The level of state dollars for drug abuse programs increased by well over 120 percent, from $80 million to $177 million during the period of Federal reductions.

In terms of the national perspective, the A.D.M S. Block Grant provides less than one-third of the monies contributed by state and local governments for substance abuse services across the country. Last year, state and local government expenditures accounted for 57 percent of the total $2.1 billion spent across the country. This compares with only 16.5 percent contributed by federal block grant funds.

Clearly, Congress recognized the need for additional funding and the necessity directed by past inequities by the overwhelming passage of the Omnibus Drug Abuse Act of 1988 and the authorization of $1.5 billion. Unfortunately, as you know, only $805 million was actually appropriated, so a tremendous gap continues to exist. These additional funds are generally viewed, the ones that were actually appropriated last year, as an initial down payment on the goal that was specified in the President's A.I.D.S. Commission Report of being able to provide treatment on demand for anyone that needs it throughout the country.

I want to address myself briefly to a question that was included in the letter of invitation to testify, and that is how are the states using these block grant funds. I would like to inform the Committee that states use a very careful and deliberate planning process to insure that the funds are utilized appropriately and in a cost effective manner directed to areas within each state where they are most needed.

There has been such publicity concerning the controversial drawdown issue. States have been criticized for not accessing federal monies as expeditiously as some would like. The Committee should

be advised that the block grant funds are available to states only 2 or 3 days before the state actually writes checks to reimburse community programs for services. Thus for most states, the Block Grant operates primarily as a reimbursement mechanism. The services are already provided. Contracts have been let with local service providers, not-for-profit agencies.

So what we're talking about is a reimbursement system wherein states advance funds for program operation. For us, it is unfortunate that the issue has been given such notoriety. If the Congressional concern is to ensure the federal monies are directed to communities to provide services, I can assure you this is precisely what is occurring.

In the Chairman's letter of invitation, he also asked for specifics with respect to the efficacy of drug abuse treatment, and he indicated that certain treatment modalities have in fact showed some measured success in treating drug abusers. I would like to point out that virtually all studies conducted over the last 15 years show that drug abuse treatment is effective in reducing drug abuse, increasing employment, improving psychological adjustment, and decreasing crime along with other negative behaviors. Indeed, the evidence to support greatly increased public expenditures of funds for drug abuse treatment is overwhelming.

The latest—and this is provided at some length in my formal testimony—and most persuasive evidence of the efficacy of treatment is to be found in the results of the Treatment Outcome Perspective Study, a study called "T.O.P.S." This is the largest and most comprehensive study of the effectiveness of drug abuse treatment ever undertaken. T.O.P.S. was a multi-year study that focused on 10,000 individuals admitted to 37 selected programs in 10 cities throughout the country. Study participants were followed in methadone maintenance, residential therapeutic, outpatient drug-free programs, and others.

The results of the study will be released and published in October 1988, but the preliminary findings show, as many previous studies have indicated, that there's a dramatic decline in drug use during and after treatment and the clients have progressed well. I would recommend this study for the members of the Committee, because I think it will place before you in a very consolidated way all the body of evidence that has accumulated over the last 15 years that point to the efficacy of treatment.

N.A.S.A.D.A.D., the organization which I represent, is in the process of undertaking a comprehensive review of all of this literature as well. We will present a paper which will spell out the efficacy of treatment, and we would be pleased to share this with the Select Committee when it is completed, which should be in the middle part of October.

In conclusion, much remains to be learned and many improvements in the treatment system are necessary. But it's clear that with only ten percent of the estimated 1.5 million I.V. drug users in treatment that much more needs to be done. The public needs to be better informed. We need a renewed commitment to treatment as a wise and prudent use of public resources. The disastrous effects of reduced federal support between 1982 and 1988 are in evi-

dence all across the country and must be addressed to reverse these trends.

I'd be pleased to answer any questions you have when it gets to that point. Thank you for the opportunity to testify.

Ms. LOWEY. Thank you very much.

[Statement of Mr. Gustafson appears on p. 102.]

Ms. LOWEY. I think what we should do is vote and then come back, because we certainly want to hear from you. Thank you very much. If you can be patient with us, we'll try and do it quickly.

The Committee will recess for ten minutes, five minutes if we can get back fast enough.

Thank you.

[Whereupon, at 1:25 p.m., the Select Committee recessed until 1:33 p.m.]

Ms. LOWEY. Mr. Coughlin, good to see you. I hope you'll share some thoughts with us today.

TESTIMONY OF THOMAS COUGHLIN III, COMMISSIONER OF NEW YORK STATE CORRECTIONAL SERVICES

Mr. THOMAS COUGHLIN. I'll be very brief. My formal statement will be made part of the record, of course.

From the perspective of a state corrections department which houses over 50,000 inmates now, we started to notice several years ago—and I've been around for over a decade now as Commissioner—that back in the late '70s and early '80s, out of our 18,000 or 19,000 admissions each year, maybe 2,000 were drug commitments. Last year, that changed to the point where out of roughly 19,000 admissions, over 10,000 were drug admissions. So the problem has mushroomed dramatically and has forced us to expand our system from roughly 18,000 beds in 1979 to 50,000 right now. And with the new appropriation for prison beds going to 56,000, almost 57,000 beds by this time next year.

Given that many people coming in every year, and given that many people who have been involved with drugs and alcohol—70 percent admit to drug abuse and another 30 percent admit to alcoholism problems, so there's 100 percent of the population with a substance abuse problem—we started back in the mid-'80s to pay close attention to drug treatment and alcohol treatment within the system. Today we have over 12,000 drug treatment slots, beds, program placements within the system for drug abuse and alcohol treatment services.

The appropriation we just received to build the 5,700 or 5,800 new beds, we tried a little something different. We are going into entire prisons now and making them drug treatment prisons. There will be over 2,000 beds by this time next year specifically allocated to drug treatment, built along the therapeutic community model, run by the Department of Corrections in term of the security administration.

But most interestingly, the treatment services will be operated by the not-for-profit groups, the Mitch Rosenthals and the Odyssey Houses, with one caveat. We find that individuals who are involved in a drug treatment program within the prison system, that treat-

ment takes and they come back to prison at a much lower rate than those individuals who are not involved in drug treatment.

The problem that we see is that we can keep the person drug-free for his two years or 28 months or 30 months that he's in prison and we can get his head right, but when he leaves the door of the prison and he goes back out into the street the aftercare services have not been there, just have not been there. And there's a major problem with relapse and the guy comes right back to us.

To try to get at that, which we feel is a major problem within the system, we have said that we will allow the treatment services at these new facilities— and they're small 200 bed places—to be operated by the not-for-profits from the community with the caveat that when the person leaves the prison he belongs to you, so that you have the continuum of services not only within the prison but also out on the street for relapse services, for treatment services, or for residential care, whatever you feel as professionals that person needs.

I am encouraged, from my experience in this business, that that's going to have a major effect on the return rate to prison, which as a prison administrator is what I look at. So that's the focus in drug treatment for the next several years for the New York State Department of Corrections.

I would like to just mention, because I was asked to mention it, our Shock Incarceration Program. It's an interesting program for young first-time offenders. It's a lot more than the press makes it out to be in terms of drills and physical training and what not. It is a true intensive six month treatment program for substance abusers. In fact, if you look at the break-down of the hours, about 500 hours of this 6 month program is allocated to military drill and ceremony, 560 hours is allocated towards drug treatment, specific drug treatment.

The entire program at each one of these camps is built around the therapeutic community model, where there is interaction and the 12 steps and all of the other things that have been accepted in the treatment community as having some reality and some efficacy. Education at the Shock Camp, again a feature that the press doesn't play up too much because it's not that sexy, we have seen dramatic increases in reading levels, math levels of individuals coming into that program, because we've got them focused. We might only have them focused for six months, but we've got them focused.

As taxpayer, I think that a lot of people would be interested to know that the individual that spends the 6 months in a Shock Camp does not return to prison at the same rate as individuals from the general population. For every 100 graduates out of that shock program, there's a savings to the State of New York of over a million dollars. And for the 18 months the program has been in operation now, we have been able so save in prison costs over $5 million.

The program is expanding. Currently, we have about 1,000 beds. There's a new 750 bed Shock Program opening next month, which will give us about 1,700, 1,800 shock beds for the system.

I will be more than happy to answer any questions about Shock or our treatment perspectives.

Ms. LOWEY. Thank you very much. I appreciate it.

As you know, we've been focusing a good deal on the Hill lately on boot camps and Shock Incarceration Treatment Centers, and we're particularly interested in your views on this. I believe New York has four, is that correct?

Mr. THOMAS COUGHLIN. Four, that's correct, operating.

Ms. LOWEY. And I would hope to visit at least one very soon. I'm particularly interested in the education component at these centers, or perhaps they're different at different centers. What kind of job training facilities do you have there? What kind of followup do you do after they leave?

My problem with the current prison system right now—I've been up to Sing Sing several times, and in fact I've taught a course there the past couple of years, and I've found in general after the inmate was released it's one parole officer to 200 parolees. I forget, it's something like $40 in your pocket, go forth young man into the world without a house, without a job, without a home, comes back to the community and someone says "Hey man, you want to make a deal," and sure, he's back on the street making $1,000.00 until he gets back into prison again.

So I'm particularly interested in the boot camp, because just as Phoenix House, this kind of regimented routine for an addict is very successful. What kind of follow-through is done in the community?

Mr. THOMAS COUGHLIN. Well, the boot camp is a different kind of community care. The normal parole officer to parolee ratio is about one to 40. In the shock program, it's one to 15. Each one of the shock—there are a couple of hard and fast rules about shock parolees.

One, no S.R.O.'s or shelters. You have to have a stable home environment somewhere. That's up to the parole officer to find that home environment for them or create it, if need be, and he does that.

No unemployment, to the point where we have developed some rather interesting arrangements with our prison industry program. Prison industry makes a lot of goods that they sell to governmental agencies in the City of New York, for example. We have made a contract with Vera, which is the criminal justice institute there in New York, who has a neighborhood work program. Vera's neighborhood work program does all the delivery and installation of the prison industry products in the City of New York. Vera hires shock incarceration graduates and pays them normal wages. So, at least when they come out of prison, for the first 6, 8, 9, 10 months, the vulnerable period of time, they've got a place to live and they've got a real job and they have very intensive parole supervision. I think that's why we're getting the results we are with them.

Ms. LOWEY. In Westchester County, we have a very successful program. It doesn't have more than 12 youngsters in it, unfortunately. It's a problem of funds again, where youngsters are admitted to this house and these living arrangements with support staff before they go to trial. Can a youngster be admitted to a shock incarceration facility before he or she goes to trial?

Mr. THOMAS COUGHLIN. Not the program that's operating now. We've set it up quite purposefully to not allow that kind of thing to

happen. We developed the shock program as a prison program. You must be convicted and sentenced to state prison. Then the judgment as to whether or not you're going to the shock program is a corrections judgment, not a judicial judgment, given the criteria that the legislature sets.

Now, that's not to say the same kind of program would not be successful with pretrial people, with people doing local jail times or with people who need some structure that haven't been involved with the criminal justice system.

It's unfortunate that you have to get arrested and convicted of a crime in New York State to have any assurance of treatment services. That's kind of crazy and that should be turned around a little bit, but again it costs money. Prisons nowadays get a lot of money. Maybe some of that money should be going to the education system or something of that nature.

Ms. LOWEY. Well, unfortunately, what we're trying to focus on today is how we find enough funds and where should we direct it for all of the above. Hopefully, if our educational system is doing what it should and our whole society is taking care of the other components of a good life, we won't give you so many clients out there. This is what we're trying to address and we're hoping we can get a national policy in place which will take away some of your potential clients.

Mr. KOEHLER. If I may, what we've heard I think consistently here today is that drug treatment works, it has an effect on the people who are treated, whether they're in jail or in prison. We've heard that the educational program seems to have an effect while people are in prison. We've heard that shock incarceration seems to have an impact. I think there's a very dramatic impact in terms of education in the jail as well. Somebody attends an educational program for 30 days in New York City run by the Board of Education, their reading level increases by 6 months. The potential is there among the inmates.

I think what we need is not—and Tom mentioned it just a moment ago as well—is not to focus on criminal—why do I have to, why do we have to be the conduit to this, why does the person first have to commit a crime or get arrested? Why do I have 1100 drug treatment beds and I'm asking for more money for drug treatment and education and Tom is doing the same thing, but he's making it contingent upon what he knows is very important, that there has to be a follow-up in the community?

I created a jail that will be exclusively drug treatment. The next question I asked myself is why do I run it? Why does the Correction Commissioner run that drug treatment program? When people get out, there's no place for them to go and they'll come back.

You really have to look at this in the broader context if you want to get at the problem. Twenty-three years in law enforcement, I spent 18 years locking people up and now five years trying to manage the result of that focus. They're not in jail because they're addicted to drugs. They hurt people and that's why they're in jail. They do muggings, they do robberies and they do burglaries, many of them many times over again.

It's very difficult to turn a person around who's been arrested five to seven times, addicted to drugs, no education and can't read.

That's what we do in Correction. We try to do that. It's a silly place to start.

Ms. LOWEY. Before I turn it over to Mr. Coughlin, one other question. Are there any alternatives to jail currently that you've been working with for drug offenders?

Mr. KOEHLER. One thing we do is a supervised detention program which the state legislature has permitted us to do now for about a year and a half, which is essentially the question you asked before, isn't there a way to put people waiting for trial into programs like this. I have the ability and we have about 30 people now waiting for trial who were sent to us by judges, who couldn't make bail, who I decided under the legislation could, in fact, be risked by being placed in the street. We put them into drug treatment, we put them into education, we put them into job training kinds of programs.

It's a very modest program. It's very modest because of Willie Horton, but it's very modest because I think an intelligent approach to this kind of a program has to concern itself to public safety. So, I'm careful who I put into it, but there is room in that kind of a program to expand what we're doing with convicted felons.

At the same time, I asked the question before rhetorically, why do I have to run the jail drug treatment program? I think there's also room for the judiciary to say to people as a condition of bail, "You'll go into this residential drug treatment program." Testimony before indicated that that kind of residential program cost about $15,000 a year. It costs about $40,000 in New York City for each of my inmates and that's no the inmate getting the drug treatment. The cost of the drug treatment is on top of that typically.

So, those kinds of alternatives, I think, would be helpful.

Ms. LOWEY. Thank you, Mr. Koehler.

Mr. Coughlin.

Mr. COUGHLIN. Thank you, Madam Chairman.

We wouldn't want you to think that this Committee is not concerned about education or about law enforcement or about other aspects of the demand side of the equation or indeed about the whole supply side of the question. These hearings just happen to be on rehabilitation. We certainly recognize that it's important to stop people from ever getting into your hands through the court system. Your particular panel is looking at rehabilitation within the criminal justice system which is to some extent different than rehabilitation outside of the criminal justice system.

My question relates to the shock incarceration approach. What kind of a recidivist rate do you get with the shock camp kind of a treatment?

Mr. THOMAS COUGHLIN. We've had graduates out there now since March, 1988. Anybody who really knows this business knows that you don't start developing recidivism rates after 18 months. However, with that caveat, I'll tell you what they are. The individuals who graduate from shock return to prison at about a 17-percent rate. The general population rate after 18 months is about 25 percent. So, they are somewhat better than the general population.

That should not be used as any measure at this point. True recidivism figures follow out 5 years. If after 5 years then you look at it, then you say, "Well, there's a marked difference, 25 percent as opposed to 40 percent," that's something. Then you say, "This is a good program."

Again it doesn't mean you shouldn't do this kind of thing. It does have an immediate fiscal benefit for the State of New York. If they're not coming back at any higher rate than the general population, and there's a $5 million benefit in the first 18 months, then you continue doing it.

Mr. COUGHLIN. And what happens to someone who washes out from the shock program? Do they go right back into regular custody?

Mr. THOMAS COUGHLIN. They go back into general population and complete their court set minimum.

Mr. COUGHLIN. When the court sets a minimum, do you have any discretion in terms of a shorter term if you go into a shock program as compared to regular incarceration?

Mr. THOMAS COUGHLIN. Shock is the only program in New York State that allows any modification of the court set minimum. The criteria is pretty clear. Anybody who has 36 months or less on their minimum sentence is eligible for shock, along with some other crime criteria. If you successfully complete shock, which is a 6 month program, you can get out of prison. Theoretically, you can cut 30 months of your minimum sentence. In actuality, the average inmate spends about 11 months in custody before he graduates from shock.

Mr. COUGHLIN. And shock then applies to both first-time offenders and other offenders as well, is that correct?

Mr. THOMAS COUGHLIN. No. Right now, shock is limited strictly to first time offenders under the age of 30. Let me clarify that. First-time state prison offenders.

Mr. COUGHLIN. Right.

Mr. THOMAS COUGHLIN. You could have individuals, the younger group could have done time in Dick's program, local jails. The 26 to 30 year old group is strictly first time offenders. No jail time, no other indeterminate or determinate sentence.

[Statement of Mr. Thomas Coughlin appears on p. 115.]

Mr. COUGHLIN. This whole concept of shock or boot camps is somewhat new. Your testimony on the issue is very useful to us.

Madam Chairman, I thank you.

Ms. LOWEY. Thank you, Mr. Coughlin.

Before we ask another question, I would like to express the apologies of the Chairman, Chairman Rangel, but his Ways and Means Committee is busy at work on the Reconciliation Tax Bill, and particularly because you are from New York, he very much wanted to be here. So, I would like to extend his apology.

I have another question for Mr. Koehler concerning what is happening—we touched on it a bit—with the inmate that is released from prison. I had some experience with the Division of Economic Opportunity in several programs that we funded dealing with *X* offenders. Never enough money. Are there some that you feel are particularly successful that are really able to have an impact on this population that is giving back to society?

Mr. KOEHLER. We've had the following experience in terms of drug treatment essentially. We began 2 years ago to use methadone maintenance as opposed to detoxification in the city jail system in New York. We opened 450 methadone maintenance beds. Last year, 3,426 people were serviced in those beds. Jails being very dynamic, a lot of people come to jail. Seventy percent of them were taken into methadone programs on the outside. So, 70 percent of the people who came through the treatment program that we began and put them into in the jail went into methadone maintenance on the outside.

We don't have the research capability yet to see whether or not they stayed in the program or for how long and it's too soon to tell what kind of recidivism rate they'll have. But that was very attractive.

Then we began drug-free programs. We'll have 600 of those beds. We began the first 150 last year. We're seeing that of those people leaving, about 40 percent now are going into treatment on the outside.

So, the drug treatment programs, you need some kind of a start for a person while they're in jail, whether it's education or drug treatment or some kind of a program for them to be in, to be transferred to the outside.

Otherwise, the average length of stay for inmates in my system is 47 days waiting for trial, 54 days under sentence. Typically, 60 percent of the people coming through jail are out in less than 14 days. So, we tailor our programs to the length of stay that people have. We do a lot of education associated with A.I.D.S. We do some education in terms of telling people where they can go on the outside. But they come through very quickly in the jail system. When we get them into a program like the drug treatment program, we look for and when we find connections on the outside, there's a very good rate of people going into the programs on the outside.

Jail is a real opportunity to get somebody started on something as opposed to prisons where you can actually give them the treatment program.

Ms. LOWEY. Hopefully they get started on all positive things, right, in jail?

Mr. KOEHLER. You're absolutely right. We don't want to train them to do bad things.

Ms. LOWEY. Thank you very, very much.

Do you have any additional questions?

Mr. COUGHLIN. No, I don't, Madam Chairman.

We thank you very much for your appearance here today and for your time.

[Statement of Mr. Lawrence Coughlin appears on p. 121.]

Ms. LOWEY. And thank you very, very much. We look forward to additional information. We hope you will continue to be a resource to this Committee. Thank you.

[Whereupon, at 1:58 p.m., the Select Committee was adjourned.]

APPENDIX

OPENING STATEMENT

OF THE HONORABLE CHARLES B. RANGEL

CHAIRMAN

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

HEARINGS ON THE EFFICACY OF DRUG ABUSE TREATMENT PROGRAMS

PART I

JULY 25, 1989

TODAY THE SELECT COMMITTE ON NARCOTICS ABUSE AND CONTROL WILL BEGIN PART I OF ITS HEARINGS ON THE EFFICACY OF DRUG ABUSE TREATMENT. AS YOU KNOW, THE DRUG ABUSE EPIDEMIC CONTINUES TO GROW. WITH RISING DRUG ABUSE, INCREASE DEMANDS FOR TREATMENT HAVE BECOME CRITICAL. THE SELECT COMMITTEE HAS RECEIVED ESTIMATES THAT 6 TO 6.5 MILLION AMERICANS ARE IN NEED OF DRUG ABUSE TREATMENT. CURRENTLY THE NUMBER OF TREATMENT SLOTS ARE DRASTICALLY INADEQUATE FOR DRUG ABUSERS SEEKING TREATMENT.

TREATMENT IS AN ANTI-DRUG STRATEGY OF NATIONAL IMPORT BECAUSE IT AFFECTS THE CONSUMER MARKET FOR THE DRUG INDUSTRY. EFFECTIVE TREATMENT REDUCES THE DEMAND FOR DRUGS BY REHABILITATING OR HABILITATING THE ADDICT SO THAT SHE OR HE NO LONGER NEEDS TO USE DRUGS TO LIVE.

LESS THAN 30 YEARS AGO, DRUG ADDICTION WAS THOUGHT TO BE INCURABLE. "ONCE AN ADDICT, ALWAYS AN ADDICT" WAS THE COMMON EXPRESSION. HOWEVER, IN 1958 SYNANON, THE FIRST THERAPEUTIC COMMUNITY, CLAIMED THAT THEY COULD KEEP FORMER HEROIN USERS FREE OF DRUGS FOR MORE THAN A YEAR. YET SKEPTICISM CONTINUED.

IN 1965, DRS. VINCENT DOLE AND HIS WIFE, THE LATE MARIE NYSWANDER PIONEERED METHADONE MAINTENANCE. THEY BELIEVED THAT MANY, IF NOT ALL, ADDICTS ARE DRIVEN TO OPIATE USE BECAUSE THEY HAVE A PERMANENT, PHYSIOLOGICAL IMBALANCE THAT OPIATES ALLEVIATE. DOLE AND NYSWANDER POSTULATED THAT METHADONE CORRECTED THIS PHYSIOLOGICAL IMBALANCE AND MET A METABOLIC NEED WHEN THE DRUG ABUSER WAS NO LONGER USING HERION.

DESPITE THE RIVALRY BETWEEN THE PROPONENTS OF DIFFERENT APPROACHES TO DRUG ADDICTION TREATMENT, IT WAS BECOMING APPARENT THAT DRUG ADDICTS COULD RECOVER AND THAT THE OLD ADAGE ABOUT DRUG ADDICTION BEING INCURABLE WAS WRONG.

DESPITE EXTENSIVE EVIDENCE THAT DRUG ABUSE TREATMENT DOES WORK, QUESTIONS ABOUT ITS EFFECTIVENESS CONTINUE TO BE RAISED. THE QUESTION ABOUT WHETHER ONE TREATMENT MODALITY IS MORE EFFECTIVE THAN ANOTHER PERSIST. THIS IS A DIFFICULT QUESTION BECAUSE THERE ARE MANY FACTORS TO CONSIDER. FOREMOST IS THE ADDICT HIMSELF. A METHADONE MAINTENANCE MODALITY MAY INITIALLY BE EFFECTIVE FOR ONE ADDICT, WHEREAS, ANOTHER ADDICT MAY RESPOND TO A THERAPEUTIC COMMUNITY, A TWELVE STEP PROGRAM OR AN OUTPATIENT DRUG FREE MODALITY. ONE UNCONTESTED FACT IS THAT THE LONGER A PERSON STAYS IN TREATMENT, NO MATTER WHICH MODALITY, THE MORE POSITVE THE OUTCOME. HOWEVER, A MAJOR CHALLENGE FOR TREATMENT PROVIDERS IS KEEPING THE CLIENT IN TREATMENT LONG ENOUGH TO BENEFIT FROM THE AVAILABLE SERVICES.

GIVEN THE FACT THAT TREATMENT WORKS AND I BELIEVE THAT IT DOES. THE FACT REMAINS THAT WE DO NOT KNOW WHAT IS EFFECTIVE TREATMENT. WE NEED TO KNOW:

- WHAT ARE THE ELEMENTS OF AN EFFECTIVE TREATMENT PROGRAM?
- HOW SHOULD TREATMENT PROGRAMS BE STRUCTURED?
- WHAT SERVICES SHOULD BE OFFERED TO THE CLIENT, NO MATTER WHAT MODALITY?

- o WHAT CRITERIA DETERMINES SUCCESS?
- o HOW DO PEOPLE GET INTO TREAMENT?
- o WHAT DETERMINES WHICH MODALITY IS FOR WHOM?
- o IF A PERSON IS PUT ON METHADONE MAINTENANCE, WHAT DETERMINES HOW LONG THIS PERSON STAYS ON METHADONE
- o WHAT IS THE AVERAGE LENGTH OF TIME AN INDIVIDUAL STAYS ON METHADONE?
- o DO THE PROGRAMS PROVIDE COMPREHENSIVE COUNSELING?
  - FREQUENT INDIVIDUAL COUNSELING
  - FREQUENT GROUP COUNSELING
  - FAMILY THERAPY
  - VOCATIONAL ASSESMENT, TESTING, CAREER PLANNING, JOB COUNSELING, JOB PLACEMENT
  - EDUCATIONAL COUNSELING, TUTORING, REMEDIAL TUTORING HIGH SCHOOL EQUIVALENCY DIPLOMA, PSYCHOLOGICAL EVALUATIONS
  - WEEKLY NARCOTICS ANONYMOUS AND ALCOHOLICS ANONYMOUS MEETINGS

CONSIDERING THE FACT THAT THE DRUG ABUSE EPIDEMIC HAS BEEN EXACERBATED BY THE AIDS CRISIS, WHETHER AIDS AND SEX EDUCATION IS OFFERED?

TO REDUCE THE PROBABILITY OF RELAPSE, THERE MUST BE AN AFTERCARE COMPONENT BECAUSE ONCE BASIC TREATMENT IS COMPLETED, THE CLIENT NEEDS TO MAINTAIN CONTINUING CONTACT WITH PROGRAMS OR BECOME INVOLED IN A SUPPORT SYSTEM FOR MANY MONTHS OR YEARS.

TODAY THE SELECT COMMITTEE BEGINS A SERIES OF HEARINGS ON THE EFFECTIVENESS OF DRUG TREATMENT. OVER THE NEXT WEEKS AND MONTHS WE WILL BE HEARING FROM A WIDE RANGE OF WITNESSES ON THIS SUBJECT, INCLUDING HHS SECRETARY SULLIVAN NEXT WEDNESDAY, AUGUST 7. HOPEFULLY WE SHOULD RECEIVE ANSWERS TO THE QUESTIONS I HAVE RAISED.

Statement of

Mitchell S. Rosenthal, M.D.
President

Phoenix House Foundation

before the

Select Committee on Narcotics Abuse and Control
United States House of Representatives

July 25, 1989

on the

Issue of Therapeutic Communities as a Treatment Modality in Treating Drug Abuse

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name is Mitchell S. Rosenthal. I'm a psychiatrist and the esident of Phoenix House ... which first opened in 1967 ... d is now the nation's largest, private, nonprofit drug abuse rvices agency ... with ten treatment centers in New York and lifornia.

have been involved in drug abuse treatment for more than a uarter of a century ... as a Navy psychiatrist ... as the irst deputy commissioner for rehabilitation of New York ity's Addiction Services Agency ... and as the founder of hoenix House.

hope the committee will bear with me today as I attempt to nravel ... as briefly and lucidly as I can ... the issue of rug abuse treatment.

lainly, this is not a simple matter. If it were, then right, able and well-meaning men and women would not have so any different ideas about what it involves ... what it can chieve ... and how this nation can best ensure that it is enied to none and accepted by all who need it.

First, let me point out that the goal of drug abuse treatment is the same as the goal of treatment for any other disorder -- a cure. But a drug abuser who has gotten off drugs for a week ... or a month ... or even a year ... cannot be said to be cured. Recovery involves more than sustained abstinence with minimal likelihood of relapse. It must include changes in those negative attitudes, values, and behavior that are as much a part of the drug abuse syndrome as chemical dependency.

Drug abusers, you must understand, are not otherwise normal people who happen to use illicit substances. Over time, drug abuse diminishes the ability to function "normally" -- to hold a job, keep up with schoolwork, or sustain responsible social, sexual, or family relationships.

Drug abusers become driven people, self-destructive, and out-of-control. Their abuse lowers self-esteem, erodes character, and prompts behavior that is anti-social, often violent, frequently criminal, and manifests an almost absolute indifference to the impact on others.

s a result, drug abuse is inextricably linked ... not only
ith increased criminality and the spread of AIDS ... but with
ising rates for almost all forms of disordered behavior --
omelessness, mental illness, teen runaways, adolescent
uicide, and child abuse and neglect.

hat we have learned over the past quarter century is that
rug abusers can achieve positive changes in attitudes,
alues, and behavior only from a therapeutic process that
nvolves them as active participants. Doctors can detoxify
assive patients. But patients themselves must make the move
rom there to drug freedom. It is not a route they can travel
lone, and traditional psychotherapy offers little help.

ll this we came to recognize during the Sixties ... when
rug-free treatment began ... and the first therapeutic
ommunities brought the self-help principles and group process
f Alcoholics Anonymous into a highly structured treatment
etting designed for heroin addicts.

Drug-free treatment has since proven to be infinitely adaptable. Drug-free programs ... both residential and outpatient. . . have been created to serve abusers of all drugs ... and all kinds of drug abusers ... adolescents as well as adults.

Drugs may vary and degrees of dependency differ, but the basis of abuse is much the same for all abusers. It is this basis ... the underlying causes of abuse ... that drug-free treatment addresses. And it enables abusers to confront and overcome the emotional problems and negative conditioning that prompt and sustain. . . not only drug abuse. . . but all kinds of antisocial and self-destructive behavior.

Drug-free programs, like those of Phoenix House, are not the only effective treatment alternatives. Programs that are not drug-free can also cure drug abuse.

Chemical interventions play a useful ... and sometimes necessary ... role. This is most true during detoxification and the early stages of abstinence. But what's important to recognize about substitute drugs, drug antagonists, and blocking drugs is that they cannot cure drug abuse by themselves.

Although methadone maintenance is an appropriate intervention for many long-term heroin addicts, it is not methadone ... the drug itself ... that "cures" the maintenance patient. Need for the drug ... to control the craving for heroin ... keeps patients returning to the clinic. There, they are involved in the counseling and therapy groups that constitute the true "treatment" aspects of these programs.

However, it is difficult for an outpatient methadone program to generate the kind of motivation ... and to make the kind of behavioral demands ... that will cause truly dysfunctional drug abusers to start changing attitudes and values. This kind of change most often requires the structure, discipline, and support that is found only in drug-free residential treatment communities.

And here we come close to the crux of today's treatment dilemma. My colleagues who operate methadone programs are divided. Many believe strongly in the need for structure and discipline. Others maintain that these "rigidities" drive addicts out of methadone maintenance treatment. They would eliminate all controls. They would reduce or eliminate counseling. They would, in certain clinics, cut out all services save for methadone resupply ... arguing that the threat of AIDS and addict crime make this necessary.

What they propose cannot be considered treatment ... for its goal is not the cure we know that drug abusers can achieve. And yet there is growing support today for a treatment strategy tilted towards greater dependence upon methadone and other chemical interventions ... including proposals to develop a methadone-like drug for cocaine and crack ... a methadone clone.

Prompting much of this support for chemical alternatives is a perception of drug-free treatment as a high-cost intervention of limited effectiveness.

And it is this perception that I would like to challenge here today.

First, let me point out that the large-scale follow-up studies of heroin addicts entering treatment that were conducted for the National Institute on Drug Abuse have found methadone maintenance and drug-free residential programs equally effective in reducing heroin use and criminal activity. Let me also note that the cost of methadone maintenance in New York runs about $3,000 a year, which is much the same as drug-free treatment for outpatients. Residential treatment, however, costs close to $15,000 a year.

But residential treatment lasts an average of 18 months. . . for a total cost of $22,500. While methadone maintenance, if successful, is lifelong. So a 25 year-old addict entering a methadone program will, if he succeeds, run up a lifetime tab of more than $150,000.

I should also note that the sole criterion of "success" at most methadone centers today is remaining in treatment. Thus, patients may be considered "successful" while using drugs other than heroin ... and this is true for about 60 percent of the methadone patients in New York. . while remaining dependent on public assistance ... or even engaging in crime.

A "successful outcome" for a drug-free patient, however, is based on post-treatment performance that includes drug abstinence, employment or full-time education, and no criminal involvement.

Long-term studies of former heroin addicts treated at Phoenix House ... followed for five and seven years after treatment ... found only five percent in one group of graduates ... and none in another had subsequently used opioids. More than half had been arrested in the year preceeding treatment ... and only one percent in the years that followed. And full-time employment rose from an average 2.2 months a year to more than 11 months.

But the rap on drug-free residential programs is that we have so few graduates. And it is true that drop-out rates are high But you should know that our studies have followed drop-outs as well as graduates. And that drop-outs also succeed. For drop-outs in the Phoenix House studies ... opioid use fell from 95 percent to 26 percent ... arrests from 63 percent to 15 percent ... and average months of full-time employement rose from 3.5 to more than 7 months a year.

Success and improvement, we discovered, were related not to graduation or failure to graduate but simply to length of treatment. "Best successes" ... with no post-treatment drug use or criminality, plus full-time employment ... were achieved by no residents who stayed for less than a month ... but by 12 percent who stayed four to six months ... by 32 percent who stayed eight to ten months ... and by nearly 40 percent who stayed a full year. Less than perfect success ... truly significant improvement which might be marred by just one instance of post-treatment drug use ... was shown by about 60 percent of the dropouts who remained in treatment for eight months.

What these numbers mean in terms of cost-effectiveness is best explained by noting just when in the treatment process most residents tend to drop out. A study of resident retention at seven therapeutic communities found dropout rates highest during the first 15 days. At Phoenix House half of all dropouts leave within the first 30 days ... most during the first five days.

Now, forget total admissions and look at how the dropout rate would affect a 10-bed dormitory at Phoenix House. Eight of those beds would be filled for the full year by eight young adults ... each of whom will go on to graduate. Two of the beds, however, will be filled, over the course of the year, by 42 different young adults who will remain for little more than two weeks each.

In terms of total admissions, that dormitory will have a dropout rate of 84 percent ... and a success rate of just 16 percent. But, at any given moment during the year, the success rate will be 80 percent. And, at year's end, 80 percent of the treatment capacity of that dormitory will have been used positively ... for young adults who will subsequently succeed.

Nor can we count out the 42 youngsters who left. A good number will return to treatment ... either at Phoenix House or at a similar program. Indeed, 16 percent of our residents are giving treatment a second shot.

I'll admit that retention is a problem ... although we've gotten it up at Phoenix House. But retention is a problem for ALL treatment programs. And it is most troublesome to those that impose the kind of discipline and behavioral demands that are necessary for drug abusers to achieve real cures.

If drug abusers are free to use drugs without fear of arrest or social sanction ... then that is what they will do. Without disincentives ... they will not enter treatment. And if they are offered treatment options that make no demands on them ... that do not even require them to stop using drugs ... then that is what they will choose. They will not choose to be cured.

What I hope this committee will recognize. . . is that we can no longer afford to leave this decision to drug abuser. We must make the decision ... and I pray we nave the sense to demand that treatment provide true cures ... that we give drug abusers ... not wi. t they want ... but what they need. . the chance to reclaim their lives.

Thank you.

Select Committee on Narcotics Abuse and Control

Testimony of Martin Valdes, M.D.
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July 31, 1989

Mr. Chairman, I want to thank you for inviting me to testify before the Select Committee on Narcotics Abuse and Control. My testimony follows those of Dr. Beny Primm and Dr. Larry Brown in 1985 and 1987, both of whom have been leaders in bringing attention to the ravages of the disease of drug addiction. I am the Associate Director for Medical Services at the Addiction research and Treatment Corporation. ARTC was formed in 1969 as a not-for-profit minority operated organization. Over its twenty year existence ARTC has pursued an ever expanding role in the delivery of comprehensive care to the drug addicted predominantly Black and Hispanic population. In fact, it has already provided services to well over 20,000 with a current enrollment of over 2,100 patients. In the process ARTC has attained an international reputation for excellence and commitment to treatment and prevention of drug addiction. Notwithstanding the prevailing financial constraints and saturation of resources for health care delivery in New York City, ARTC has succeeded in enlarging its provision of community services. The encroaching AIDS epidemic has presented a particularly difficult challenge to a system already strained. Because of its dedication to the people it serves ARTC has made its primary goal to find creative solutions in delivering comprehensive care including primary health care and addiction treatment to a large population at risk. Occasionally, of course, this has entailed defying the laws of thermodynamics and creating energy or matter out of nothing.

I have carefully re-read the statements by Dr. Primm and Dr. Brown to the Ninty-Ninth Congress and the One-Hundredth Congress Select Committees. Although some progress has been made since their last appearance here the litany of problems continues to grow. It weighs heavy on a minority population already oppressed by myriad problems including a widening gap between the haves and have-nots, discrimination, unemployment, lack of education, stigmatization, crime and on and on.... In addition the drug addict population was already beset by higher prevalence of many disease including tuberculosis, viral hepatitis, sexually transmitted disease, bacterial endocarditis, and other diseases of chronic undernourishment and stress. But this was already true many years before the advent of the Human Immunodeficiency Virus. Therefore we should ask what was done to combat these problems? Maybe some paper was shifted back and fourth up here but actually very little trickled down to where I stand. I propose that nothing or at least very little was done. The renewed interest in this unrepresented minority stems partly from their potential threat as entry points for the spread of AIDS among the majority heterosexual population. Should this disease have proven to be contained in the poor Blacks and Hispanics I doubt very much the interest would have been long lived. This is particularly true for the drug addicted who are perceived as social deviants, noncompliant, uneducated,

angry, destructive, dangerous, untrustworthy and they got what they asked for attitude. Why were their problems ignored for so long and furthermore why are they going to remain largely ignored unless drastic steps are taken? Let me half tongue-in-cheek suggest an answer: Habituation. I think a passage from Sharpless and Jasper writing in the journal Brain in 1956 illustrates best what I mean:

> If a drop of water falls on the surface of the sea just over the flower like disc of a sea anemone, the whole animal contracts vigorously. If, then, a second drop falls within a few minutes of the first, there is less contraction, and finally, on the third or fourth drop, the response disappears altogether (Jennings, 1906). Here in this marine polyp with the primitive nerve net is clearly exhibited one of the most pervasive phenomena of the animal kingdom - decrement of response with repeated stimulation. Almost every species, from amoeba to man, exhibits some form of response decrement when the stimulus is frequently repeated or constantly applied (Harris, 1943). The ubiquity of the phenomenon plus its obvious survival value suggests that this kind of plasticity must be one of the most fundamental properties of animal behavior.

The problems of the addict have been the repeated drops: The decrement of response has only been an expected fulfillment of a fundamental animal property. This entrenched habituation has led to a condition which Ralph Ellison best describes as the invisible man:

> I am an invisible man.
> I am a man of substance, of flesh and bone, fiber and liquids and I might even be said to posses a mind. I am invisible, understand, simply because people refuse to see me.

AIDS has been the response sensitization: it has led to an increased response as a result of another strong stimulus. It is interesting to note that this phenomenon of habituation has not been as common with other groups. I suspect that the reason may be these other groups are articulate, well funded and well represented. Everytime Congress was falling into a decrement of response or habituation these groups would lobby their problems into a revived awareness. But who lobbies for the drug addicted? They themselves are unable since their daily activities mostly revolve around survival and providing for their basic needs which include craving for opiates. Lobbying is a luxury which they don't have. How can they effectively organize when they are already plagued by the problems already mentioned in addition to being victims of the Rosenthal effect. According to T. Beny Brazelton as talking with Bill Moyers in A WORLD OF IDEAS, Rosenthal says if you label somebody, and they know the label - and people always do - then they live up to that label. A group of rats was

divided into two and labeled "dumb rats" and "smart rats". Graduate students were instructed to put them through a maze. It seems that none of the "dumb rats" were able to get through the maze whereas all the "smart rats" did. Interestingly , a film taken of the handling of the rats showed the students picking up the "smart rats" in a different way than the "dumb rats." The drug addicted population has been labeled nonconcomplaint, ciminal, angry, destructive and so the label sticks regardless of what characteristics are real and which are myth. Take for example compliance. Some opponents of increased services to substance abusers and in particular primary care services counter that the task is futile at best since the IVDA is perniciously noncompliant. Actually this notion is probably more stereotypical than real but it gets recited as one of the main reasons for the unwillingness to deal with this group. We have done a survey of our appointments made versus appointments kept and have found the compliance rate to be 50%. This rate is roughly equivalent to that of the population at large, therefore showing that misunderstanding and lack of knowledge may have once again prevailed over objective assessment.

This population has become invisible or at least we have made it so. Let me demonstrate this with some numbers. As of March 2, 1989, 6,450 persons were enrolled or had previously participated in AIDS clinical trials at one of the sites sponsored by the National Institute of Allergy and Infectious Diseases. Yet, only 6.5% of the persons were female, 8.5% were non-white, and 89% had never used drugs This is in great contrast to the representation of these groups in HIV morbidity and mortality. By February 13, 1989, the Centers for Disease Control (CDC) had received reports of 86,157 cases of AIDS with IVDAs representing 27% of the total. At least one-fourth of all AIDS cases reside in New York State. This higher number experienced by New York is most likely because of its very large community of substance abusers. Perhaps up to 6% of the state's population or 850,000 persons are substance abusers with 258,000 of these thought to be regular IVDAs. This is nearly 65% of the 400,000 regular IVDAs nation wide. Additionally in New York City Blacks and Hispanics had a higher cumulative incidence of AID cases than any other racial or ethnic group in any other state.

By now you should have concluded the problems are multitudinous. The onslaught of HIV has made a desperate situation even worse. With lack of resources and very few choices in the struggle, we have to stand back and strengthen what is at our disposal. A comprehensive approach to drug addiction is the best weapon we have. It is not the strongest because it is the only approach. It is the strongest because if properly implemented it has shown a degree of success that compares favorably to other modalities. A prerequisite, however, for a successful course requires the placing of the addictions unequivocally within the medical model. It is a disease entity with a psychophysiopathology, with an etiology

or etiologies, with a mechanism of occurrence. It is capable of being studied at the basic science level and at the epidemiological level. Futhermore, one of its manifestations, heroin addiction, has a medication for treatment: Methadone. Unfortunately this therapeutic agent has been fraught with misunderstanding, clouded by moral pronouncements, evaluated by people that lack the expertise or experience to reach objective conclusions. Curiously, this is part of the overall irrational approach to drug addiction. Witness the separation of the management of drug addiction from the Department of Health and its placement under a different department. Witness the misconceptions still rampant about methadone such as: you are trading one drug for another or it is not a cure. Well, antihyperhensives are not a cure, insulin is not a cure, most antineoplastic agents do not cure but provide a period of remission. Somehow we do not give up on these modalities or attach a stigma to their use. Observe the recent series of articles in a major New York daily which indict methadone, the providers of methadone and the addicts. A big issue is made of the relapses of the patients. That some urine toxicologies are still positive for cocaine and heroin meaning continued use. Meanwhile it ignores the not insignificant number of patients who while on methadone are employed and lead productive family lives. There is mounting evidence that patients stabilized on methadone maintenance show a significant rise in employment. Any system has non-compliance. Nonetheless we don't indict the diabetic when he cheats on his diet or the hypertensive who cheats on his salt intake or forgets to take his medication. On the contrary we reinforce, counsel, find alternative incentives for better compliance.

The treatment of drug addiction must be comprehensive. It must include general education, counseling both social and psychological, group therapy, medical intervention, outreach efforts, teaching basic life skills, job counseling, prevention, child care services, primary care services in the treatment centers with strong affiliation with tertiay care centers. The education must be directed to the substance abuser and the community at large. All of this must take place in a climate free of myth and political agendas. As Dr. Zinberg writing this summer in Daedalus has pointed out, "education campaigns have amounted to indirect attempts to promulgate social policy rather than dispense facts, and they have promoted the most simplistic moral and politically "correct" positions, whether about illicit drug use or AIDS".

The commitment to drug addiction must change drastically. Dr. Beny Primm has proposed a "supermarket" approach to the problem whereby the treatment is specifically geared to the individual patient's needs. He or she is welcomed into a comprehensive treatment center. There he or she and even their family receives those modalities of treatment best suited to the individual wether acupunture, drug free-status with mild counseling, primary care services, etc... Some

patients will benefit from accelerated re-entry into the mainstream while some patients will require life long treatment. This is not unique to addiction but holds true for most medical diseases. Dr. Marie Nyswander in her "Drug Addiction in the United States: Past and Present" has described the lot of the drug addict most eloquently.

> Drug addiction is a distinct medical entity which ravages the patient, destroys the entire fabric of his life, and adversely affects the lives of his family and others close to him.
>
> As in every major disease, the patient is helpless before its destructive inroads. Struggle as he may, the curious and inexorable process overwhelms him, no outer moral compulsion can stay it; no authoritarian decree can cut it short. Punishment is meaningless, imprisonment futile, in halting the relentless course of the disease.

We expect and prepare for relapses and complications in every other disease. Why should we demand more of the drug addicted? Why should we be so quick to judge and further alienate a group that has already been labeled as a pariah. We must remember that the road to recovery is sometimes

> "Never ending, still beginning
> Fighting still, and still destroying" (Dryden).

PSYCHIATRY ADDICTIONOLOGY

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July 25, 1989

Testimony Before the Select Committee on
Narcotics Abuse and Control

Thank you for the opportunity to share my experience and ideas with the Committee. Briefly, I am a psychiatrist and certified Addictionologist, mostly in active private practice for 28 years, having treated 15-20,000 drug addicts and alcoholics of whom 3-4,000 have been "illicit drug addicts."

Dr. Koop warns that the drug abuse epidemic combined with AIDS is the major threat to our society. There are very few single substance abusers. Since our average addict, at age 26, snorts or smokes cocaine, smokes marijuana, may use heroin and PCP, and washes it down with two six-packs of beer, we have alot to look at. We often concern ourselves with just illicit drugs. Unfortunately drugs neither know or care whether they are licit or not and go on about their business of destroying our young adult population. Prescription drugs, particularly the tranquilizers, impair the lives of four or five million of our older adults. An accurate view must include alcohol, the oldest, most important drug in the world. Thus we have 15 million victims (at least) if we cover all the drugs. Addiction is the most common illness of the American, ages 15 to 40.

To attend to the current effort of the Select Committee, in understanding and enhancing narcotics treatment, we must look at what works and what does not. Conventional psychotherapeutic approaches have proven of little value. Methadone maintenance has been quite useful and helpful but only to 25 or 30% of those on those programs. How then do people get well.

The treatment of choice for addictive and many other behavioral illnesses is the self-help 12-step program. These steps consist of simple principles; trust God, clean house and help others. These programs become "a way of life" for the patient. The founding program, Alcoholics Anonymous (1935), is best known to us all. Narcotics Anonymous, beginning in California in the early 50s, moved East in the middle 50s and now, after 30 years, is as well established as AA was in the mid 60s. Hopefully, as our drug problems intensify, Narcotics Anonymous can do for the drug addict what Alcoholics Anonymous has done for the alcoholic.

It is a privilege to share my experience, strength and hope with you.

Joseph F. Chambers M.D.

Joseph F. Chambers, M.D.

Testimony of Michael O. Smith, Presented to the Select Committee on Narcotics of the House of Representatives

Good afternoon, my name is Michael O. Smith. I am the Medical Director of the Substance Abuse Division, the Department of Psychiatry of Lincoln Hospital. It is an honor to speak before the Congress about our clinical work. We are indeed fortunate to be able to use the many thousand year tradition of acupuncture for the benefit of many of New York's most under-served citizens. The administrative and professional staff at Lincoln Hospital and the Health and Hospitals Corporation, particularly Dr. Billy Jones and Dr. Jo Ivey Boufford, have given us long and consistent support in our efforts.

I am a physician and psychiatrist who has learned acupuncture on the job in the South Bronx. I completed resdency at Lincoln and then worked for their outpatient methadone detoxification program beginning in 1972. I remember being initially skeptical that such an apparently delicate process such as acupuncture could have a real impact on drug addiction. However, 15 years of large scale clinical experience has persuaded many of us of the popularity and effectiveness of acupuncture treatment. Currently 250 detoxification patients receive acupuncture daily at Lincoln. Our program provides acupuncture treatment in a large community room where most patients seem to be relaxing or meditating. Each day 45-50 women bring infants and small children with them to our clinic. Typically the young mother will sit with a baby in her lap while receiving acupuncture.

Acupuncture is a foundation for psycho-social rehabilitation so that counselling, drug-free contracts, educational and employment referrals, and Narcotics Anonymous are essential parts of the program. Acupuncture not only

controls withdrawal symptoms and craving, but it also reduces and fears and hostilities that usually disturb drug abuse treatment settings. Acupuncture has a balancing effect on the autonomic and neurotransmitter systems as well as an apparently rejuvenating effect. Drug abuse treatment is accomplished by inserting 3-5 acupuncture needles just under the skin or surface of the external ear. Needles are sterilized by autoclave. The location of ear points and the technique of insertion can be taught easily so that most acupuncture components can be staffed by a wide range of substance abuse clincians. Chapter 663 of the laws of New York State was passed in 1988 to establish that acupuncture conducted in a state approved drug treatment program will be exempt from normal licensing provided that proper training and supervision take place.

Alliance with Criminal Justice System

In January, 1987 our clinic population was suddenly transformed by the avalanche of cocaine-based "crack" that continues to threaten our lives. We have all read about the bizarre, intractable nature of crack addiction. In professional meetings we have been told that there is no known treatment for the craving and fearful cycles of crack. From the beginning our experience at Lincoln has been strikingly different than these reports.

8,000 crack patients have been treated at Lincoln--many more patients than have been seen at any other program. Crack abusers seek treatment earlier in the course of their illness than other addicts. They often have a longer history of prior drug-free status than other abusers.

We have developed a protocol that is specifically intended to serve criminal justice clients rather than merely grafting probation and parole-referred clients onto a treatment structure designed for voluntary walk-in clients. I believe our program has had the highest success ever recorded in the treatment of an unscreened court mandated population seen on an out patient drug-free basis.

More than 50% of these clients have provided negative urine toxicologies for more than 2 months. We have received no adverse reports on these individuals. Certainly, the Lincoln Hospital Acupuncture Program has the best record in New York City for the treatment of court referred crack abusers.

A computerized tracking system was set up with the assistance of Dr. Stan Altman of Stony Brook (SUNY) so that any client's urine testing record could be located at a moment's notice. Lincoln tests urines for cocaine and heroin on a daily basis with EMIT system located on the premises. Therefore a probation officer, for instance, can receive a substantial, precise, and up-to-date report on any client with one phone call. This system is much more appropriate than written correspondence for the hectic and often chaotic work pattern in criminal justice service agencies. Staff members from probation, parole and family court frequently call for status reports. They also visit the Lincoln clinic and may have a joint session with the client and Lincoln counselor on such an occasion. Our clients exhibit considerable confidence in this system which allows their frequent toxicology reports to speak for them in court.

55 clients referred by the NYC Probation Department are listed in our 1987-88 records. Most of these clients have received probation with a requirement for drug abuse treatment. Some of our most successful clients have been referred to Lincoln during the pre-sentencing probation investigation. The statistical data can be summarized in the following manner: 11 of the 55 clients (20%) attended Lincoln only once. 30 of the remaining 44 clients (68%) have responded quite well to treatment and have provided consistently negative urine toxicologies. This group of 30 successful clients has attended Lincoln for an average of 9 consecutive weeks over a total span of more than 4 months. The pre-sentencing clients were assigned to probation instead of receiving prison time. One man who was facing 30 years of federal time for drug-related charges has been sentenced to probation because of his 6 month record of clean urines. This man still attends NA meetings here every Saturday with his 8 year old son.

The judges involved have been clearly impressed by our clients' long record of clean urines on an out-patient basis. The successful clients have been re-established. After completing the Lincoln Hospital program, clients often continue long term drug-free recovery programs, including AA and NA.

A joint project to provide long term evaluation of Lincoln clients is being conducted by the NYC Probation Department, the Police Foundation of Washington,D.C. and ourselves. Our plans include a properly matched controlled study with 2 year follow-up of a substantial number of clients.

In a preliminary study we have traced the outcomes of 34 clients referred to Lincoln by NYC Probation in 1987-88. Six (6) of the 34 clients (17%) attended Lincoln only once. Eighteen (18) of the remaining 28 clients (64%) have attended more than 10 visits over a range of 2-15 months. Only one of these 18 clients has had his probation revoked and has been sent to prison. Five (5) of the 18 clients have functioned so well on probation that they were given "early discharges" from the probation system. Five of the clients who attended less then ten visits were re-arrested and none were given early discharge. Hence frequent attendance at Lincoln correlates with a 5:1 improvement in outcome for this series of clients.

The possibility of diverting people from incarceration is a very high priority in our field because of overcrowding and the lack of revenue. The National Association of Criminal Justice Planners has placed a high priority of acupuncture detoxification in many jurisdictions where crack is rampant.

Nationwide Implementation of this Criminal Justice Program

In April, 1987 I was invited to Portland, Oregon by Judge Nely Johnson and a criminal justice advisor to the mayor. A pilot program was established in the public detox unit. In June the county voted to allow $60,000 of their federal Bureau of Justice Administration funds to create several acupuncture components. Presently 6 new programs have been established by David Eisen of the Hooper Foundation, the county's contract agency for drug and alcohol

treatment. The detoxification program now reports that 85% of its patients complete thir program. Before acupuncture was used, only 34% completed the program. The 6 month recidivism rate has dropped from 25% to 6%. The Oregon State Department of Correction has helped establish a Criminal Bed Reduction Program using acupuncture to treat men charged with drug and alcohol-related offenses up to the level of class C felony. A clinic for runaway youth and a community-based program have also been started.

State funding is earmarked for AIDS intervention IV drug treatment programs in Portland, Salem and Eugene. AIDS outreach workers will be giving out acupuncture coupons in addition to condoms and bleach. The State has suggested a Medicaid reimbursement rate of $28 per treatment with an allotment of daily treatment for 3 months and weekly treatment for a year. All clinicians will be required to be NADA-certified.

Let me quote from an independent evaluation report prepared by Carolyn Lane for Multonomah County.

"The succesful post-detox enrollment rate is somewhat higher for all acupuncture participants than for non-participants and much higher--nearly double, or 43% versus 25%--for participants who had 7 or more treatments. The size of the follow-up group, which is about one-third of all clients discharged from Hooper Center in a year, and the lengthy follow-up period of more than one-third of a year, make this finding very impressive".

"Outpatients were asked, as part of their Acupuncture Progress Reports, to note their attendance at self-help recovery groups or their enrollment in other post-detox or recovery programs. Of those that did, about two-thirds attended Alcoholics Anonymous or Narcotics Anonymous meetings, most once or twice a week but some every day".

"Without exception, the clients interviewed were enthusiastic about acupuncture. One "needed less medicine to relax, to sleep", another felt the

desire to use substances "just fade away", and several remarked they were less tense, less fearful, and "able to cope with things a lot better". Another commented that "with acupuncture, you're moving toward something".

"A major advantage of acupuncture is that treatment can begin immediately, while treatment programs require a client assessment, with its associated costs. The first of these is simply the fixed cost of performing a client evaluation. If the client drops out at this point, as frequently occurs with unstable individuals, the cost of evaluatior plus any potential billing for treatment is lost. In addition, the loss is a source of endemic low morale among caseworkers and counselors. Acupuncture treatment does not require such an evaluation and can begin at first contact, in many cases thus retaining clients who would not return otherwise".

"In conclusion, acupuncture appears to be a very cost-effective modality in supplementing and supporting a comprehensive detoxification treatment program. Also, it provides an adjunct treatment that can be applied during the entire cycle of detoxification".

Judge Herbert Klein of Miami-Dade County has spearheaded the development of an acupuncture-based program in the prison stockade and an outpatient facility in Overton. The program which focuses on criminal justice clients begin in May 1989 and sees 100 people daily.

Suggested Reasons for the Success of this Criminal Justice Program

(1) Acupuncture is a popular and effective treatment. Patients learn to have confidence in daily acupuncture visits and the relief that consistently occurs. Acupuncture is a treatment for craving and fear as well as withdrawal symptoms. This modality facilitates constructive, non-antagonistic counselling and breaks down the barriers that usually inhibit group process. The consistently

calm atmosphere in the treatment area is a marked contrast to the tense mood of streets and of even the best conventional drug program. Acupuncture acts physiologically by enhancing the patient's own balancing mechanisms. There is a renewed development of vitality and integrity from within before external challenges need to be taken up. In this clinical setting passive-aggressive dependency and adolescent acting-out are greatly reduced. Staff and patients alike can focus on stability and growth without the interpersonal statis that usually limits communication.

(2) We have applied many of the basic principles of chemical dependency which are often neglected in criminal justice related situations. The struggle for sobriety is "one day at a time". By testing urines on a daily basis, providing daily acupuncture, and encouraging brief daily counselling sessions--we are functioning in the same rhythm as the patient's struggle for recovery. Testing urines every two weeks, in contrast, functions as an external judgmental process that clashes with the potential rhythm of recovery. A common principle of AA is "keep it simple".

(3) Our clinical staff makes a primary allience with the criminal justice referral agency as well as with the client. This process of dual allience with the client and the disciplinary agency is the basis for successful work in Employee Assistance Programs. The process is not at all contradictory as long as the primary focus is on sobriety and increasing the client's integrity which is the common goal of all parties. Unfortunately many treatment agencies see themselves as adversaries to the courts and end up by disguising the results of sobriety testing and making excuses for continued abuse. This pattern is called "enabling" in our field. The Lincoln clients are very accepting of this "dual allience" strategy. There is a lack of contradictory messages, a lack of excuses, and an abundance of interest in their daily struggle to be drug-free.

(4) The counselling process at Lincoln emphasizes a non-judgemental, non-invasive, supportive approach. The firm challenge of sobriety is established, but the treatment relationship is quite flexible and open ended. On some days patients may want to ventilate their feelings each day; at other times they may want to just say "hello" and take the acupuncture treatment. Patients often experience fear and resentment toward intrusive questions and advice. This phenomenon is particularly true with court-mandated clients. These fears often prevent frequent attendance at otherwise helpful programs. The therapy program cannot "hold a grudge" and put increasing pressure on the atient for previous failures to respond to treatment. Pressure and concern must be appropriate to the quality of today's struggle and not reflect the residue of the past. The use of acupuncture makes this non-judgmental process much easier.

(5) Frequent urine testing provide an objective non-personalized measure of success that can be accepted equally by all parties. In this system the counselor is the "good cop" and the urine machine is the "bad cop". The counselling process can be totally separated from the process of judgment and evaluation. According to this approach clients will not feel a need to be friendly to their counselor in order to gain a positive evaluation. The computer print-out showing a series of drug-free urines is the only documentation they will need to gain a favorable report for the court.

(6) Clinical supervisors at Lincoln have developed an approach that encourages self-sufficiency in their colleagues. A counselor who perceives that his or her autonomy is respected will be much more able to develop autonomy in individual clients. The treatment field frequently neglects the principle that autonomy is a major component of health and sobriety. So much effort is focused on referrals to 24 hour facilities that this basic and practical reality often fades out of view. No matter how effective 24 hour rehabilitation is, the patient will spend 99% of the time in an independent

state. The pressing reality of criminal justice is comparable. To help people, we need to help them function well independently of our agencies.

(7) The fear and shame associated with impending incarceration or removal of a child is certainly an importantfactor in any success. In the chemical dependency field, it is considered beneficial for a prospective patient to face a fearful concrete reality. The myth of the well motivated walk-in patient is just that: a myth. Similarly court-related referrals should always be made with definite requirements. Referrals of the type "why don't you see if this treatment can help you" lead to an unusually low rate of success. According to recent trends of budget deficit and court congestion, the threat of incarceration is often more symbolic than real. The response of probation and SSC clients indicate that a temporary, more-or-less symbolic threat may often be quite effective in persuading a client to begin treatment and these clients continue in treatment long after the circumstances suggesting the threat of punishment abated. This type of situation is actually quite typical of interventions and contracting in chemical dependency treatment.

(8) "There is no such thing as a hopeless case" is another basic principle. The Lincoln program does not screen out prospective patients as "poorly motivated" or "unsuitable" as is frequently done in regard to criminal justice referrals. All referrals are accepted: A fact that makes these statistics all the more promising.

Suggestions for the Future

In cooperation with the primary referral sources, Lincoln is developing a selection of treatment contracts that can be mandated for criminal justice clients. For example, a parole client might be required (1) to attend acupuncture 5 days a week for a minimum of 3 weeks, (2) provide drug-free urines on at least 10 of the first 20 days of treatment, (3) drug-free urine

once a week for a subse quent 6 months, (4) attendance at Narcotics Anonymous or equivalent program for 6 months. Note that these requirements allow some leeway in the early period of treatment and continue to require sobriety during the early recovery period. Another client might be mandated to give 6 weeks of daily urines and up to a 2 year follow-up period. Such contracts could easily become the basis of revenue saving court diversion and early release programs. Unsuccessful clients would face incarceration, but a sizeable number would be spared by their commitment to a drug-free life.

At a recent NYC Bar Association retreat, I suggested that drug abusers who are identified by the police sometimes be given summons instead of being arrested. The summons might require that the abuser provide a number of negative urine toxicologies during a specified period of time in order to avoid actual arrest. The vailability of effective and inexpensive acupuncture treatment for crack abuse makes this type of non-institutional management a legitimate possibility to cope with the huge dimensions of our drug abuse epidemic.

Millions of Dollars Have Been Saved Each Year By Treatment of Crack Mothers

One of the bittersweet realities of public service is the opportunity to confront major problems of the day as they develop, much as an explorer discovers new territory and learns to cope with new dangers. Often we are overwhelmed or simply lack methods to handle a given situation. One of the worst symptoms of the crack epidemic has been the massive increase in maternal substance abuse and consequent retention of cocaine-positive infants in hospitals as boarder babies. Many of these infants are deprived of love and nurturing until their mothers are able to receive successful drug abuse treatment. As virtually the only available outpatient program for crack abuse

in the city, Lincoln Hospital has received more than three thousand referrals of drug abusing mothers in the past 30 months. We are pleased to report that the Lincoln Hospital Acupuncture Program appears to have saved the city more than 3 million dollars in 1987 by reducing costs of boarder babies and subsequent foster care for infants born of crack-abusing mothers. The hospital and Special Services for Children (SSC) refer nearly all maternal patients to the acupuncture program. Their attendance and urine results are satisfactory enough so that the agency and the courts release custody of the infants in most cases. Most city hospitals are severely overcrowded and drained of resources due to the boarder baby crisis. Millions of dollars are lost unnecessarily; hospital nurseries are prevented from helping infants with medical needs; and numerous children remain separated from potentially caring parents. The Lincoln acupuncture program is a reliable alternative to much of the suffering and deprivation of maternal substance abuse.

We sent Dr. Wendy Chavkin, then Director of Maternal Health for the City Health Department, the following reports describing 290 post-partum women whose babies were held in the hospital because of a positive cocaine toxicology. 70% of all post partum referrals interviewed by our staff have attended acupuncture treatment and counseling on a regular basis for at least two (2) consecutive weeks. 50% of all referrals have provided an average of 10 or more clean urines on a regular basis. In one series, post partum clients provided twice as many clean urines after regaining custody of their child as compared to the pre-custody testing period. These women completed an average of 3 months of attendance in our program. 50% of them attend NA meetings. The use of acupuncture detoxification has produced substantially beneficial results in this large scale clinical trial.

Special Challenges for Women in Substance Abuse Treatment

Lincoln Hospital is the only drug abuse program that I know of which has a large number of child-rearing female clients. Usually female clients in drug programs are rather street-oriented and accommodate to the dominant male clients in that manner. Child-rearing for these women is generally a secondary activity. Lincoln works with many of these street-oriented women. However, a large part of our maternal substance abuse caseload consists of women who identify primarily as homemakers and parents. These women sometimes have outside employment but they almost always have a "job" at home raising children and coping with domestic pressures. Drug abuse activities invade their home life, but once drug-free status is regained these women have a respectful "job" that they can return to. Consequently these women have needs that are quite different than the needs of an unemployed person who might have marginal skills and time on his hands.

Female drug abusers are often trapped in very destructive and exploitative relationships. Many drug-related relationships involve violence and abandonment. When we ask a mother with small children to stop using drugs, we are usually asking her to leave her home and her relationship as well as the identified addiction. These women are often foced to live in a shelter or welfare hotel if they leave the apartment where their crack-using companion remains in physical control. In a previous session of this subcommittee we heard that shelters and welfare hotels are hardly safe harbots in the drug abuse war. A woman with small children is uniquely vulnerable to the intimidating and intrusive nature of the crack sub-culture.

Immediate pressures of child care may also hinder a woman's response to treatment. We instruct acupuncture patients to sit quiety in the chair while the needles are in place. This request takes on an entirely different meaning when the maternal patient has a newborn and a 2 year old with her. Attendance

in Narcotics Anonymous is also more difficult when children tag along. Every day in our clinic 45-50 women bring small children with them during treatment. We appreciate their commitment to parenthood, but also recognize the increased challenge of their regular attendance. Many of our new mothers visit the hospital each day to feed their infant. Others have to make difficult arrangements for child care.

All too often women are said to have greater resistance to treatment than men. Reality-based fear of physical violence may be falsely interpreted as only part of their fear of confronting addiction. Dependence on living in an apartment and a relationship where crack happens to be used will compound the apparent degree of dependence on the drugs.

At Lincoln we have been able to design a program with a relatively high rate of success for women with small children. Acupuncture provides convenient relaxation and reduction of fear on a daily basis. Scheduled appointments are not necessary. Frequent supportive sessions are used rather than early stage confrontations that are often typical of drug-free programs.

Let me conclude this discussion by mentioning one principle that is vital to the success of any maternal substance abuse program. The program must work in terms of the women's autonomy and ask her to become drug-free for herself not "for the sake of the baby". Guilt is not a good medicine. A person who appreciates her own value will be a better parent and also be able to say no to drugs and drug-filled relationships.

Enhancements of the Maternal Substance Abuse Program

New York City Council President Stein's office designated $181,000 of fiscal 1989 to establish a unique pre-natal substance abuse program at LIncoln Hospital. The pregnant substance abuser is treated initially for addiction as the primary problem. She receives acupuncture, counselling, urine testing, using the regular protocol. Education about pregnancy and delivery,

pelvic examination and more stressful testing will be conducted as the patient seems ready to handle these matters. City Controller Harrison Goldin has designated $110,000 in the fiscal 1990 budget to develop parent education program in conjunction with our post-partum program. The Department of Health will help us track long term follow-up for these patients as well as our whole post partum case load.

AIDS Prevention

As we have indicated, acupuncture detoxification is a popular and safe method of relieving stress and craving in a wide range of substance abusers. More than 60% of substance abuse clients are retained in acupuncture treatment, a much higher figure than any other form of out-patient drug-free treatment. No other drug abuse program except for Lincoln has ever been able to accept poly-drug abusers and mentally ill chemical abusers on an unscreened walk-in basis so that 10 new patients daily can receive acceptable treatment on the day of admission. Lincoln Hospital has a long history of being able to reach the unreachable patient--including some homicidal, paranoid, and bizarrely psychotic persons. The following patient summaries indicate the capability of an acupuncture program to reach "unreachable" clients. The patients described are typical of the segment of AIDS patients who will be most difficult to relate to and therefore will be more likely to spread the condition.

H.W. came to our clinic with a narcotic and cocaine habit and an obviously paranoid condition. He had a history of LSD psychosis in 1972 and at least 3 state psychiatric hospitalizations. H.W. was evidently hearing voices and reported bizarre somatic delusions. H.W. attended acupuncture 5-6 days a week for the next 6 months. After the first day he said that his voices "went away". Use of heroin and cocaine continued intermittently. H.W. was so guarded that no individual verbal sessions were attempted until 6 months

later. H.W. is now readily communicative, working part-time and attends acupuncture weekly.

K.D. had been a patient in our treatment program before serving 2 1/2 years in jail. He was a bizarre, visibly troubled 40 y/o man who was quite socially isolated. K.D. stabbed one of our other patients, F.P., away from the clinic site. K.D.'s parole officer was not able to return him to prison and was not able to transfer him to another treatment program. K.D. had such a trouble-making reputation that he was rejected by wardens and clinicians alike. K.D. and F.P. often received acupuncture in the same room simultaneously. Both relaxed easily with treatment. There was never a hint of any disturbance. K.D. has experienced substantialy periods of sobriety. His mind has become so much stronger and clearer that he has been able to be interviewed by clinicians visiting our facility.

Involving the HIV(+) or PWA person in drug abuse treatment can be the first step in the overall medical treatment of AIDS and a necessary step in the development of sexual responsibility which will protect spouses from the epidemic. The Health Commissioner Steven Joseph has strongly supported this point of view in previous testimony before the New York City Council.

The statistic that is most often cited as an indication of the danger of heterosexual spread of AIDS is the rate of HIV(+) tests in crack-abusing mothers and their babies. These statistics have been used to advocate programs such as methadone maintenance and syringe exchange; programs which relate primarily to male narcotic addicts. Helping a man use narcotics "safely" will not necessarily help him use sexual precautions with women he is involved with. The use of cocaine and alcohol tends to increase sexual irresponsibility.

Only a program which directly helps young women become drug-free will have a substantial effect on the rate of HIV(+) findings in mothers and

children in the special context of widespread infection in New York City. These women can then involve their partners in treatment. One of our patients told me her husband walked with her to the clinic with a baseball bat in case she did anything wrong. From my office window I could see the man standing on the street with a bat. Two weeks later this patient brought her husband into the clinic with her for treatment, saying "he doesn't use drugs, he just wants a treatment for nerves". Our patient had made a tremendous accomplishment--an accomplishment that could have easily been sabotaged by premature confrontation.

Medical-Scientific Reaction

We are frequently asked about the reaction of the medical scientific community to our use of acupuncture. I remember my own skepticism and certainly understand a natural reluctance to consider the possibility that acupuncture could be effective for such a serious condition as cocaine addiction.

Dr. Milton Bullock and acupuncturist Patricia Culliton of Hennepin County Medical Center in Minneapolis began to use a placebo protocol to evaluate our Lincoln Hsopital acupuncture procedure in 1983. Their first article was published in the Alcoholism journal in June 1987. It showed that 37% of the treatment group responded well to acupuncture as compared to 7% of the placebo group which received non-specific acupuncture points.

The Hennepin group has just published a more advanced study in Lancet (June 24, 1989), the prestigious journal of the British Medical Association. 21 of 40 treatment acupuncture patients completed the program compared to 1 of 40 controls. Significant treatment effects persisted at the end of a six month follow-up. These studies focus on severe recidivist alcoholics who are very rarely engaged in outpatient management.

Dr. Mindy Fullilove of the University of California at San Francisco is just completing a controlled placebo study using the Lincoln protocol with IV heroin abusers. Dr. Stephen Kendall and his staff at Beth Israel in New York have planned a controlled study using acupuncture in the treatment of addicted babies. Dr. Doug Lipton of the Narcotic Drug Research Institute (NDRI) is presently conducting a controlled placebo study using crack patients at Lincoln Hospital. In the recent submission of large scale AIDS prevention drug abuse treatment grants, acupuncture was the second most common procedure suggested for evaluation.

In a recent legislative meeting in Albany, N.Y. the chief representative of the Medical Society of New York stated that acupuncture was an important part of the health care field and that physicians were seeking more instructive and more active participation in the acupuncture field.

Relations with the Drug Abuse Treatment Field

I have always supported the position that acupuncture can only be a component part of the whole process of drug abuse treatment. Nearly all of the existing acupuncture drug abuse programs were developed within already existing licensed treatment programs. Our enabling legislation in New York State was written by Public Health Commissioner Deborah Prothrow Stith, the state drug abuse agency of Massachusetts has funded four acupuncture-based programs during 1989. Numerous methadone programs have established acupuncture components in order to treat crack abuse and other secondary addictions. In a therapeutic Community setting, such as the Phoenix House in London, staff members report that acupuncture helps reduce craving, tension among the clients and that most of the clients participate in the weekly acupuncture sessions.

A South Bronx Clinic has Gained World-Wide Recognition

The Lincoln Hospital acupunture program has received a great deal of national and international attention. More than 60 clinics in the U.S. and another 25 in Europe, Latin America and Asia have been established explicitly on the model of our clinic in the South Bronx. Indeed Lincoln Hospital has become a "mecca" for visitors and journalists. Television networks from Spain, Italy, Brazil, Sweden, Britain, Latin America, Hungary and Japan have filmed our acupuncture drug abuse program.

The National Acupuncture Detoxification Association (NADA) was founded in 1985 by clinicians who wanted to extend the example of the Lincoln Hospital experience into other treatment settings. I am the chairperson of NADA. The organizational name also uses the Spanish connotation of "nada", suggesting a no-nonsense, drug-free approach. NADA has conducted many training programs for public institutions and communities in undeveloped areas. It has set standards of certification for acupuncture detoxification specialists that are widely accepted in the substance abuse field.

I have just returned from a United Nations meeting in Spain scheduled to plan community-based treatment programs on a widely diversified basis. In the December 1988 issue of the Bulletin of Narcotics we described NADA programs on the Sioux reservation in Kathmandu, in La Perla in Puerto Rico, and Lincoln as an example of the effectiveness of this model in difficult socio-economic settings.

It is easy to be confused by the aggressiveness that many addicts present and to conclude that the main goal should be symptom suppression.

In fact the addict himself takes this approach in the extreme by using sedative narcotics. In Chinese medicine the lack of calm inner strength is described as "empty fire" (xu huo), because the heat of aggressiveness burns out of control when the calm inner tone is lost. The hostile paranoid climate of communities vulnerable to drug abuse is a clear example of an energy-depleted condition with empty fire burning out of control.

Our patients seek greater power and control over their lives. Empty fire is the illusion of power: an illusion that leads to more desperate chemical abuse and senseless violence. Acupuncture is an effective treatment for empty fire. The patient is empower, but in a soft, easy and long-lasting manner.

TESTIMONY OF RICHARD J. KOEHLER
COMMISSIONER, NEW YORK CITY DEPARTMENT OF CORRECTION

UNITED STATES HOUSE OF REPRESENTATIVES
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL
JULY 25, 1989

GOOD MORNING, AND THANK YOU FOR INVITING ME TO MEET WITH YOU TODAY. MY NAME IS RICHARD KOEHLER, AND I AM THE COMMISSIONER OF THE NEW YORK CITY DEPARTMENT OF CORRECTION. I AM ALSO THE CHAIRMAN OF THE LEGISLATIVE COMMITTEE OF THE AMERICAN JAIL ASSOCIATION. I HAVE BEEN ASKED TO TALK WITH YOU THIS MORNING ABOUT ONE OF, IF NOT THE MOST SERIOUS CHALLENGES FACING MY DEPARTMENT, OUR CITY AND THE NATION. WE ARE INUNDATED IN NEW YORK, AND IN CITIES AND COUNTIES AROUND THE NATION, WITH HUGE INCREASES IN THE JAIL POPULATION, AND WITH CORRESPONDING INCREASES IN THE NUMBERS OF INDIVIDUALS WHO COME TO US WITH SUBSTANCE ABUSE PROBLEMS.

I HAVE BEEN ASKED TO AND WILL DISCUSS THE CORRECTIONAL ASPECT OF THIS PROBLEM. HOWEVER, LET ME BE CLEAR ON ONE THING FROM THE OUTSET. WHILE I BELIEVE THAT DEVELOPING AND IMPLEMENTING CORRECTIONAL STRATEGIES TO DEAL WITH DRUG DEPENDENT INMATES IS TERRIBLY IMPORTANT, SUCH PROGRAMS WILL DO LITTLE TO "SOLVE" THE CRISIS. WE MUST, AS A NATION,

ATTACK THIS PROBLEM BY FOCUSING ON OUR CHILDREN. OTHERWISE, THE PROBLEMS OF THE NEXT GENERATION WILL MAKE US LOOK BACK ON TODAY AS "THE GOOD OLD DAYS".

MY PRESENTATION TODAY WILL BE BASED ON OUR EXPERIENCE IN COPING WITH THE DRUG CRISIS AS IT EFFECTS THE POPULATION IN THE JAILS. THE NEW YORK CITY DEPARTMENT OF CORRECTION HAS DEVELOPED AND IMPLEMENTED INNOVATIVE PROGRAMS TO RESPOND TO THE NEEDS OF DRUG ABUSERS. WE ARE PROUD OF OUR EFFORTS, AND TODAY I WOULD LIKE TO SHARE THREE THINGS WITH YOU:

- A DETAILED DESCRIPTION OF THE SUBSTANCE ABUSE PROBLEM IN NEW YORK CITY JAILS;
- AN OUTLINE OF THE INITIATIVES WE HAVE IN PLACE TO ADDRESS THIS PROBLEM;
- AND, MY VIEWS ON THE STEPS WE MUST TAKE IN THE FUTURE TO DEAL MORE AGGRESSIVELY WITH THE DRUG ABUSE CRISIS.

BEFORE I OUTLINE OUR INITIATIVES, I THINK IT IS IMPORTANT TO UNDERSTAND SOME BASIC FACTS CONCERNING THE NEW YORK CITY DEPARTMENT OF CORRECTION. WE HAVE RESPONSIBILITY FOR ADMINISTERING 17 JAILS; TODAY, AS USUAL, THESE FACILITIES ARE OPERATING AT OVER 100% OF CAPACITY, WITH ALMOST 19,000 INDIVIDUALS IN OUR CUSTODY. OUR JAILS ARE DISTINCT FROM

PRISONS IN SEVERAL WAYS:

- WE EXPERIENCE RAPID INMATE TURNOVER: OVER 100,000 INDIVIDUALS ARE ADMITTED TO OUR CUSTODY EACH YEAR, WITH AN AVERAGE LENGTH OF STAY OF 39 DAYS;
- OVER 65% OF THE INMATES IN THE NEW YORK CITY SYSTEM ARE PRE-TRIAL OR PRE-SENTENCE DETAINEES.

THE INDIVIDUALS REMANDED TO OUR CUSTODY HAVE MANY PROGRAMMING NEEDS. IN addition TO THEIR SUBSTANCE ABUSE PROBLEMS, WHICH I WILL OUTLINE IN DETAIL IN A MOMENT, SEVERAL OTHER IMPORTANT FACTS ARE CRITICAL TO UNDERSTANDING THE PROBLEMS OF DEALING WITH OUR INMATE POPULATION:

- 60% OF THOSE ADMITTED TO OUR CUSTODY READ BELOW A FOURTH GRADE LEVEL;
- 90% OF ALL INMATES HAVE DROPPED OUT OF SCHOOL BY GRADE 10;
- 10% OF THOSE IN OUR CUSTODY SPEAK A PRIMARY LANGUAGE OTHER THAN ENGLISH;
- 83% OF ALL INMATES ARE UNEMPLOYED AT ARREST AND LACK JOB READINESS SKILLS;

THE DEPARTMENT HAS EXPERIENCED TREMENDOUS GROWTH IN

RECENT YEARS, WITH THE INMATE POPULATION HAVING GROWN BY ALMOST 20% FROM THIS DATE LAST YEAR.

CERTAINLY, THE SUBSTANCE ABUSE EPIDEMIC IS GROWING AT EQUALLY EXTRAORDINARY RATES, SPREADING THROUGH OUR COMMUNITIES AND OVERWHELMING THE CRIMINAL JUSTICE SYSTEMS IN JURISDICTIONS ACROSS THE UNITED STATES. IN NEW YORK, WE ARE SEEING THE CONSEQUENCES AMONG THE INMATES IN OUR FACILITIES, AS INDICATED BY THE FOLLOWING STATISTICS:

- 83% OF INMATES SURVEYED IN MARCH 1989 REPORT USING DRUGS AT LEAST ONCE A WEEK PRIOR TO ARREST;
- 39% OF INMATES SURVEYED IN MARCH 1989 REPORT USE OF MORE THAN ONE DRUG PRIOR TO ARREST;
- 74% OF INDIVIDUALS GIVEN URINE TESTS IN MANHATTAN CENTRAL BOOKING IN MARCH 1988 TESTED POSITIVE FOR COCAINE;
- OVER 18,000 INMATES RECEIVE METHADONE DETOXIFICATION EACH YEAR;
- THE CITY DEPARTMENT OF HEALTH ESTIMATES THAT 50% OF THE INMATE POPULATION HAS A HISTORY OF IV DRUG USE, AND, THEREFORE, 20-25% OF THE INMATE POPULATION IS HIV POSITIVE.

THESE FIGURES, COUPLED WITH INFORMATION REPORTED ANECDOTALLY, INDICATE THAT THE INMATES IN NEW YORK CITY ARE PLAGUED BY SUBSTANCE ABUSE PROBLEMS, WHICH HAVE OFTEN LED TO THEIR INCARCERATION. MOREOVER, INMATES' ADDICTION PROBLEMS HAVE CONTRIBUTED TO THE DETERIORATION OF THEIR FAMILY LIFE, THEIR HEALTH, THEIR ABILITY TO OBTAIN AND SUSTAIN EMPLOYMENT, AND THEIR ENTIRE WAY OF LIFE. BY THE TIME INMATES WITH SUBSTANCE ABUSE PROBLEMS REACH THE JAILS, THEY ARE TRULY INDIVIDUALS IN CRISIS.

THE ENTRY OF THIS CRISIS POPULATION INTO JAIL IS A CRITICAL POINT IN TRYING TO BEGIN TO ASSIST THEM IN RECOGNIZING THEIR DRUG ABUSE PROBLEMS. WE HAVE FOUND THAT INMATES ARE MORE RESPONSIVE TO INTERVENTION SOON AFTER THEIR INCARCERATION; THEY TEND TO BE SOMEWHAT INTROSPECTIVE AND THEY ARE COGNIZANT OF THE CONSEQUENCES OF THEIR LIFESTYLE. EXPERTS ALSO AGREE THAT INDIVIDUALS WHO SUCCESSFULLY COMPLETE 30-60 DAYS OF PRE-TREATMENT ARE MORE LIKELY TO CONTINUE LONG-TERM TREATMENT. I BELIEVE THE NEW YORK CITY DEPARTMENT OF CORRECTION HAS RESPONDED TO THE DRUG ABUSE CRISIS WITH POSITIVE AND CREATIVE INITIATIVES THAT ARE SENSITIVE TO THESE CONCERNS. I AM ALSO ENCOURAGED BY OTHER EFFORTS BEING MADE AROUND THE COUNTRY. THE AMERICAN JAIL ASSOCIATION HAS THREE MODEL PROJECTS THAT HAVE GOOD POTENTIAL. THESE PROJECTS ARE

FUNDED BY THE U.S. DEPARTMENT OF JUSTICE. ONE IS IN COOK COUNTY, ILLINOIS, ONE IS IN PIMA COUNTY, ARIZONA AND ONE IS IN HILLSBOROUGH COUNTY, FLORIDA. WE ARE CAREFULLY MONITORING THESE PROGRAMS TO EVALUATE THEIR IMPACT.

SEVERAL SUBSTANCE ABUSE PROGRAMS HAVE BEEN IMPLEMENTED AND/OR EXPANDED IN NEW YORK CITY FACILITIES WITH THE ENCOURAGEMENT AND SUPPORT OF MAYOR EDWARD I. KOCH SINCE I BECAME COMMISSIONER IN SEPTEMBER 1986. TWO OF THESE INITIATIVES ARE OPERATED IN CONJUNCTION WITH THE NEW YORK STATE DIVISION OF SUBSTANCE ABUSE SERVICES. THESE PROGRAMS ARE IN ADDITION TO THE METHADONE DETOXIFICATION PROGRAM WHICH SERVES 18,000 INMATES PER YEAR:

- IN MARCH 1987, KEEP, A METHADONE MAINTENANCE PROGRAM, WAS IMPLEMENTED. THIS PROGRAM GUARANTEES PARTICIPANTS SLOTS IN COMMUNITY-BASED METHADONE PROGRAMS UPON THEIR RELEASE. OVER 2,000 MEN AND WOMEN PARTICIPATE IN KEEP EACH YEAR, AND 72% OF THOSE DISCHARGED HAVE REPORTED TO COMMUNITY-BASED PROGRAMS.
- IN OCTOBER 1987, A 50-BED DRUG-FREE THERAPEUTIC PROGRAM, PROMESA, WAS IMPLEMENTED TO PROVIDE SERVICES FOR ADOLESCENT INMATES. OVER 650 INMATES HAVE ENTERED THE PROGRAM, AND 60 INDIVIDUALS DISCHARGED WERE PLACED

IN COMMUNITY BASED TREATMENT AS AN ALTERNATIVE TO THEIR INCARCERATION.

IN ADDITION TO THESE PROGRAMS, WE ARE VERY PROUD OF OTHER SUBSTANCE ABUSE SERVICES WHICH ARE PROVIDED TO INMATES THROUGH INDEPENDENT ORGANIZATIONS AND VENDORS, INCLUDING REGULAR ALCOHOLICS ANONYMOUS AND NARCOTICS ANONYMOUS GROUPS IN ALL FACILITIES. TOGETHER THESE INITIATIVES REPRESENT AN IMPORTANT FIRST STEP TOWARD MEETING THE NEEDS OF INMATES WITH SUBSTANCE ABUSE PROBLEMS.

NEVERTHELESS, WITH THE INCREASE IN THE NUMBER OF ADDICTED INMATES, AND IN PARTICULAR, THE NUMBER OF INMATES ADDICTED TO CRACK/COCAINE, WE BECAME CONVINCED THAT A MORE COMPREHENSIVE, CREATIVE APPROACH WAS REQUIRED TO RESPOND APPROPRIATELY TO THIS OVERWHELMING PROBLEM. SPECIFICALLY, WE BELIEVE THERE IS A NEED TO PROVIDE EXPANDED SERVICES FOR INMATES WITH AN EMPHASIS ON EFFECTIVE INTERVENTION FOR CRACK/COCAINE ABUSERS.

THEREFORE, WE DEVELOPED AN INNOVATIVE APPROACH TO MEET THESE GOALS. THIS SUMMER, WE WILL COMPLETE IMPLEMENTATION OF A DRAMATIC NEW INITIATIVE THAT I BELIEVE CAN SERVE AS ONE MODEL FOR JAIL DRUG ABUSE SERVICES. THE PROGRAM IS DESIGNED

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TO PROVIDE A THERAPEUTIC SERVICE SYSTEM FOR INMATES WHERE SERVICES ESCALATE IN INTENSITY THE LONGER A PARTICIPANT STAYS IN THE PROGRAM. THOSE WITH LONGER STAYS, WILL BE HOUSED IN A JAIL FACILITY DEDICATED SOLELY TO SUBSTANCE ABUSERS. I BELIEVE THIS IS THE ONLY FACILITY OF ITS SIZE AND KIND IN THE COUNTRY. ALMOST 400 INMATES WILL BE IN TREATMENT AT THIS FACILITY AT ANY GIVEN TIME. FUNDING FOR THIS FULL JAIL PROJECT WAS ACQUIRED JULY 1, 1989 AND TODAY 125 INMATES IN THE JAIL ARE IN TREATMENT.

OUR PROGRAM REGIMEN BEGINS IN OUR NEW ADMISSION FACILITIES WHERE INMATES ARE RECRUITED FOR PROGRAM INTERVIEWS. ELIGIBLE INMATES, IDENTIFIED BY COUNSELORS, ARE TRANSFERRED TO DESIGNATED HOUSING AREAS IN ANOTHER FACILITY, KNOWN AS SCREENING AND ASSESSMENT UNITS. INMATES STAY IN THESE UNITS 5 TO 7 DAYS AND OUR COUNSELORS PROVIDE SERVICES, INCLUDING:

- EVALUATION OF THE INMATE'S SUBSTANCE ABUSE NEEDS;
- ADMINISTRATION OF THERAPEUTIC SERVICES, INCLULING ACUPUNCTURE, TO ALLEVIATE WITHDRAWAL SYMPTOMS;
- DISTRIBUTION OF MATERIALS LISTING COMMUNITY-BASED TREATMENT PROGRAMS AND SERVICES OFFERED BY THESE PROGRAMS.

WE ESTIMATE THAT OVER 9,000 INMATES WILL BE SERVED EACH YEAR IN THE 150 BEDS DEDICATED TO SCREENING AND ASSESSMENT.

INMATES IN THESE UNITS WHO ARE ELIGIBLE FOR MORE INTENSIVE INTERVENTION WILL BE TRANSFERRED TO ONE OF OUR THERAPEUTIC HOUSING UNITS, EITHER IN THE 400-BED JAIL OR IN HOUSING AREAS OF OTHER JAILS WHICH WE HAVE SET ASIDE FOR THIS PURPOSE. ALL OF THESE HOUSING UNITS ARE HIGHLY INTENSIVE, STRUCTURED LIVING AREAS. INMATES IN THIS PHASE OF THE PROGRAM PARTICIPATE IN GROUP COUNSELING, INDIVIDUAL COUNSELLING, AND RELAPSE PREVENTION PROGRAMMING. IN ADDITION, WE WORK TO SECURE PLACEMENTS WITH COMMUNITY BASED PROGRAMS FOR INMATES WHO ARE TREATMENT READY.

TWO THERAPEUTIC HOUSING UNITS, NAMED "SERENITY HOUSE" AND "DIGNITY HOUSE" BY THE INMATES LIVING IN THEM, BEGAN OPERATION IN JANUARY AND MAY RESPECTIVELY ON RIKERS ISLAND. NEARLY 300 INMATES HAVE ENTERED THESE UNITS, AND 23 OF THOSE DISCHARGED FROM SERENITY HOUSE AND DIGNITY HOUSE HAVE BEEN PLACED IN COMMUNITY-BASED ORGANIZATIONS; 19 OF THOSE INMATES ARE STILL IN TREATMENT TODAY.

AS I MENTIONED ABOVE, THIS SERVICE DESIGN IS BEING EXPANDED BY DEDICATING AN ENTIRE FACILITY TO DRUG TREATMENT.

ONE OF OUR "FLOATING JAILS", THE BIBBY RESOLUTION, WILL BECOME THE CORE OF OUR DRUG-FREE INITIATIVE, PROVIDING ALMOST 400 BEDS FOR THERAPEUTIC HOUSING. IN ADDITION TO THE INTENSIVE SUBSTANCE ABUSE SERVICES PROVIDED, ALL DAILY ACTIVITIES IN THIS FACILITY, INCLUDING MEALS AND RECREATION, WILL BE PROVIDED WITH THE THERAPEUTIC CONCEPT IN MIND. WE BELIEVE THIS COMPREHENSIVE APPROACH TO PRE-TREATMENT WILL PROVIDE A MEANINGFUL BALANCE BETWEEN THE SERVICE NEEDS OF THE INMATES AND THE SECURITY OF THE FACILITY. BY THE FALL OF 1989, WE WILL HAVE SET ASIDE OVER 1,100 BEDS TO OFFER INTENSIVE DRUG INTERVENTION PROGRAMING TO OVER 4,000 MEN AND WOMEN A YEAR.

TREATMENT EXPERTS AGREE THAT INDIVIDUALS WHO ARE SUCCESSFUL IN THIS JAIL-BASED PROGRAM HAVE A GREATER CHANCE FOR SUCCESSFUL COMPLETION OF LONG-TERM TREATMENT. IT IS IRONIC, THEREFORE, THAT THERE ARE INSUFFICIENT COMMUNITY-BASED RESOURCES IN PLACE TO PROVIDE APPROPRIATE CONTINUING TREATMENT FOR INMATES WHO PARTICIPATE IN OUR PROGRAMS. WE ARE FRUSTRATED TO KNOW THAT WE WILL DISCHARGE OVER 4,000 TREATMENT-READY INDIVIDUALS EACH YEAR, YET THE MAJORITY WILL RETURN TO THE STREET WITH NO SERVICES AVAILABLE TO THEM. THIS IS CERTAINLY THE LARGEST GAP IN THE SERVICE CONTINUUM WE HAVE ESTABLISHED.

THE NEW YORK CITY DEPARTMENT OF CORRECTION IS COMMITTED TO MAINTAINING THE DELIVERY OF APPROPRIATE SUBSTANCE ABUSE SERVICES TO INMATES. WE WILL CONTINUE TO EXPLORE OPTIONS FOR ADDITIONAL PROGRAMMING. HOWEVER, THIS NATION MUST PROVIDE A MORE AGGRESSIVE, SUBSTANTIVE RESPONSE TO THE DRUG WAR ON SEVERAL FRONTS IF WE ARE TO SUCCEED:

- FIRST, EDUCATION AND PREVENTION EFFORTS MUST BE EXPANDED. WITHOUT INITIATIVES TARGETED TO YOUNG PEOPLE AND POTENTIAL SUBSTANCE ABUSERS, THE JAIL POPULATION AND THE DRUG EPIDEMIC WILL BOTH CONTINUE AND GROW AT ALARMING RATES.

- SECOND, RESOURCES MUST BE INCREASED TO SERVE ALL INDIVIDUALS WHO DESIRE TREATMENT. CREATIVE NEW TREATMENT STRATEGIES MUST BE IDENTIFIED TO ADDRESS THE NEEDS OF CRACK/COCAINE USERS, THE MOST RAPIDLY GROWING GROUP OF SUBSTANCE ABUSERS. WE MUST BE PREPARED TO BE FLEXIBLE, PERHAPS TRYING SEVERAL TREATMENT MODELS TO DETERMINE THE MOST EFFECTIVE APPROACH. THERE MAY BE MANY VIABLE ALTERNATIVES AVAILABLE THAT HAVE POTENTIAL FOR LEADING ADDICTS TO A DRUG-FREE LIFESTYLE. AS I NOTED EARLIER, WE WILL BE PROVIDING ACUPUNCTURE THERAPY IN THE JAILS AS A PART OF OUR

PROGRAM, AND THE AMERICAN JAIL ASSOCIATION IS SUPPORTING OTHER EXPERIMENTAL MODELS.

- THIRD, LINKAGES BETWEEN EFFECTIVE JAIL-BASED PROGRAMS AND COMMUNITY TREATMENT ORGANIZATIONS MUST BE CREATED, TO ENSURE THAT INMATES WHO BEGIN TREATMENT HAVE ACCESS TO APPROPRIATE LONG-TERM TREATMENT RESOURCES. CURRENTLY, THE GREAT MAJORITY OF INMATES WHO LEAVE OUR PROGRAMS AND RETURN TO THE STREET HAVE NO TREATMENT SERVICES OR SUPPORT SYSTEM AVAILABLE TO THEM.

- FOURTH, FUNDING MUST BE SET ASIDE FOR PRISON-BASED SUBSTANCE ABUSE SERVICES. THIS WILL ENSURE THAT ALL INMATES IN JAIL-BASED PROGRAMS WHO RECEIVE PRISON SENTENCES WILL RECEIVE EXTENDED TREATMENT DURING THEIR PRISON TERM.

- FIFTH, ADDITIONAL FUNDING MUST BE SET ASIDE FOR JAIL-BASED SUBSTANCE ABUSE SERVICES, TO GUARANTEE THAT ALL INMATES IN NEED WILL RECEIVE ADDICTION TREATMENT SERVICES AT THE MUNICIPAL LEVEL.

- FINALLY, FUNDING MUST BE EXPANDED FOR CREATIVE ALTERNATIVE TO INCARCERATION PROGRAMS WHICH INCLUDE

DRUG TREATMENT.

THE TREATMENT AND PREVENTION SERVICES I HAVE DESCRIBED ARE EXTENSIVE, AND I KNOW OF NO OTHER CORRECTIONAL SYSTEM IN THE UNITED STATES THAT OFFERS PROGRAMS WITH SUCH A BROAD RANGE OF SERVICES. GIVEN THE RAPID TURNOVER OF OUR POPULATION, THE IMPLEMENTATION OF THESE INITIATIVES HAS BEEN AN ESPECIALLY DIFFICULT CHALLENGE. NEVERTHELESS, THESE PROGRAMS AND THE PROGRAMS SUPPORTED BY THE AMERICAN JAIL ASSOCIATION CLEARLY INDICATE OUR WILLINGNESS TO BE CREATIVE AND FLEXIBLE IN RESPONDING TO THE DRUG EPIDEMIC.

AMONG CORRECTION PROFESSIONALS, YOU WILL FIND MANY ADVOCATES FOR INCREASING SUBSTANCE ABUSE TREATMENT IN THE COMMUNITY. THIS WOULD HELP TO ADDRESS ONE OF THE FUNDAMENTAL FACTORS FOR THE GROWTH IN THE NUMBER OF INDIVIDUALS SENT TO JAIL EACH YEAR. YET, WE CONTINUE TO DEDICATE MORE MONEY TO JAIL AND PRISON CONSTRUCTION WHILE FUNDING FOR SUBSTANCE ABUSE AND OTHER CRITICAL SOCIAL WELFARE SERVICES REMAINS LIMITED.

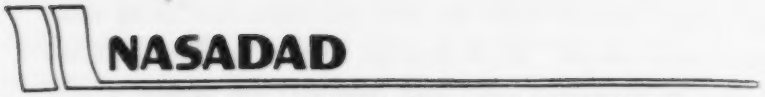
I BELIEVE THAT THIS ILLUSTRATES ONE OF THE MORE GLARING SHORTCOMINGS IN OUR EFFORTS TO IMPROVE PUBLIC SAFETY BY REDUCING ADDICTION AND CRIMINAL CONDUCT WHICH IT BREEDS. OUR

RESPONSE HAS BEEN TO FOCUS PRIMARILY ON ENFORCEMENT AND INCARCERATION. TO AN EXTENT, THIS IS AN APPROPRIATE AND NECESSARY POLICY, PEOPLE ARE NOT IN JAILS BECAUSE THEY ARE ADDICTS. THEY ARE IN JAIL BECAUSE THEY ARE ACCUSED OR CONVICTED OF CRIMES. HOWEVER, ENFORCEMENT AND IMPRISONMENT ALONE DO NOT ADDRESS THE FUNDAMENTAL PROBLEMS: ADDICTION, POVERTY, LACK OF EDUCATION AND SOCIAL ALIENATION.

THE NEW YORK CITY DEPARTMENT OF CORRECTION WILL SUSTAIN THE EFFORTS I HAVE DESCRIBED TODAY. OTHER JAILS AND PRISON SYSTEMS WILL ALSO DO THEIR BEST I AM SURE. BUT A MUCH MORE SIGNIFICANT AND CREATIVE RANGE OF HOUSING, HEALTH, EDUCATION, CHILD WELFARE AND SUBSTANCE ABUSE PROGRAMS MUST ALSO BE IN COMMUNITIES ACROSS OUR COUNTRY. IN THE LONG RUN EVERYONE, INCLUDING OUR INMATES, BUT ESPECIALLY THE GENERAL PUBLIC WILL BENEFIT FROM AN INCREASE IN THESE BASIC SERVICES AND A COMMITMENT TO COMBAT THE DRUG ABUSE EPIDEMIC MORE AGGRESSIVELY.

IN THE FINAL ANALYSIS, IN THE FACE OF A PROBLEM THE DIMENSION OF WHICH WE FACE TODAY, THE CRIMINAL JUSTICE SYSTEM CAN MAKE A CONTRIBUTION BUT TRULY SUCH CONTRIBUTIONS WILL ONLY BE IN THE CONTEXT OF A HOLDING ACTION. THIS NATION CAN SOLVE ANY PROBLEM IT SETS OUT TO SOLVE. WHEN WE AS A NATION

GET REALLY SERIOUS ABOUT THE DRUG AND CRIME PROBLEM WE WILL SEE A REAL CHANGE. WE IN CRIMINAL JUSTICE HAVE THE WILL AND ENERGY TO DO WHAT WE CAN. WHEN THAT WILL AND ENERGY CHARACTERIZES NATIONAL EFFORTS IN EDUCATION PROGRAMS, CHILD CARE PROGRAMS, DRUG TREATMENT PROGRAMS AND ECONOMIC DEVELOPMENT PROGRAMS, THE PROBLEM WILL BE ON ITS WAY TO SOLUTION.



NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS
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TESTIMONY OF

JOHN S. GUSTAFSON

DEPUTY DIRECTOR

DIVISION OF SUBSTANCE ABUSE SERVICES

STATE OF NEW YORK

and

PRESIDENT

NATIONAL ASSOCIATION OF STATE ALCOHOL AND
DRUG ABUSE DIRECTORS

before the

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL
UNITED STATE HOUSE OF REPRESENTATIVES

on

FEDERAL AND STATE ROLES IN DELIVERY OF DRUG ABUSE SERVICES

JULY 25, 1989

GOOD MORNING, MR. CHAIRMAN AND MEMBERS OF THE SELECT COMMITTEE. THANK YOU FOR THE OPPORTUNITY TO APPEAR BEFORE YOU TODAY TO ADDRESS FEDERAL AND STATE ROLES IN THE DELIVERY OF EFFECTIVE ALCOHOL AND OTHER DRUG ABUSE TREATMENT SERVICES.

MY NAME IS JOHN GUSTAFSON. I AM DEPUTY DIRECTOR OF THE DIVISION OF SUBSTANCE ABUSE SERVICES FOR THE STATE OF NEW YORK AND AM APPEARING BEFORE YOU TODAY AS THE PRESIDENT OF THE NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS, INC. (NASADAD). NASADAD IS A NON-PROFIT ORGANIZATION WHOSE MEMBERSHIP IS COMPRISED EXCLUSIVELY OF THE STATE AND TERRITORIAL OFFICIALS DESIGNATED BY THE GOVERNORS TO ADMINISTER THE PUBLICLY FUNDED ALCOHOL AND OTHER DRUG ABUSE TREATMENT AND PREVENTION SYSTEM.

ROLE OF THE FEDERAL GOVERNMENT IN WORKING WITH THE STATES TO PROVIDE EFFECTIVE ALCOHOL AND DRUG ABUSE TREATMENT SERVICES

THE PUBLICLY FUNDED ALCOHOL AND OTHER DRUG ABUSE PREVENTION AND TREATMENT SYSTEM RELIES ON FINANCIAL SUPPORT FROM ALL LEVELS OF GOVERNMENT - FEDERAL, STATE AND LOCAL. THIS PARTNERSHIP EFFORT HAS EVOLVED OVER THE PAST TWO DECADES WITH THE ROLES AND RESPONSIBILITIES OF THE VARIOUS GOVERNMENT ENTITIES CHANGING OVER THE YEARS. THE FEDERAL GOVERNMENT'S INITIAL EFFORTS WERE TO PROVIDE NATIONAL LEADERSHIP AND TO STIMULATE STATE AND LOCAL GOVERNMENT PARTICIPATION IN THE DEVELOPMENT OF A WELL-COORDINATED

AND COMPREHENSIVE SERVICE DELIVERY SYSTEM.

WHEN THE ALCOHOL, DRUG ABUSE AND MENTAL HEALTH SERVICES BLOCK GRANT WAS AUTHORIZED IN 1981, THE RESPONSIBILITIES OF THE FEDERAL GOVERNMENT FOR THE ADMINISTRATION OF THE FEDERAL ALCOHOL AND DRUG ABUSE SERVICES PROGRAMS WERE EASED SIGNIFICANTLY. WHILE THE STATES WERE WELL PREPARED TO HANDLE ADDITIONAL ADMINISTRATIVE DUTIES, THEY WERE NOT PREPARED FOR THE DRASTIC REDUCTION IN FEDERAL FINANCIAL SUPPORT THAT ACCOMPANIED THE CREATION OF THE ADMS BLOCK GRANT PROGRAM.

IN FY 1980 (THE BASE YEAR FOR THE ALCOHOL AND DRUG PORTION OF THE BLOCK GRANT) FEDERAL APPROPRIATIONS FOR THE ALCOHOL AND DRUG ABUSE PROJECT AND FORMULA GRANT PROGRAMS TOTALED $332 MILLION. IN FY 1981, FEDERAL FUNDING WAS REDUCED TO $262 MILLION AND IN FY 1982 TO $225 MILLION. IN FACT, IT WAS NOT UNTIL FY 1987, WITH THE PASSAGE OF THE 1986 ANTI-DRUG ABUSE ACT (P.L. 99-570) AND THE CREATION OF THE NEW ALCOHOL AND DRUG ABUSE TREATMENT AND REHABILITATION BLOCK GRANT THAT ANY FEDERAL FUNDING INCREASES WERE APPROPRIATED FOR ALCOHOL AND OTHER DRUG ABUSE TREATMENT.

FEDERAL FINANCIAL SUPPORT OF NEW YORK STATE'S DRUG ABUSE EFFORTS DECREASED BY 39 PERCENT FROM FY 1980 TO FY 1982 WHEN THE ADMS BLOCK GRANT WAS IMPLEMENTED. FURTHERMORE, NEW YORK SUFFERED A CUMULATIVE LOSS OF NEARLY $66 MILLION IN FEDERAL FINANCIAL ASSISTANCE FOR DRUG PROGRAMS SINCE THE SHIFT TO BLOCK GRANT

FUNDING. BY CONTRAST, MR. CHAIRMAN, NEW YORK HAS CONSISTENTLY SUPPORTED AN INCREASE IN STATE DOLLARS FOR SUBSTANCE ABUSE EFFORTS AND DURING THE YEARS OF DECLINING FEDERAL SUPPORT, 1982-1988, THE LEVEL OF STATE DOLLARS FOR DRUG ABUSE PROGRAMS INCREASED BY OVER 121 PERCENT, FROM $80.2 MILLION TO $177.6 MILLION. YOU MAY ALSO BE INTERESTED TO KNOW THAT NO STATE COMMITS MORE OF ITS RESOURCES TO DRUG AND ALCOHOL TREATMENT AND PREVENTION THAN DOES NEW YORK.

IN ADDITION TO REDUCED FEDERAL FINANCIAL SUPPORT FOR TREATMENT SERVICES, THE FEDERAL GOVERNMENT ALSO LESSENED ITS NATIONAL LEADERSHIP ROLE WITH THE ELIMINATION OF MANY DATA COLLECTION EFFORTS, TECHNICAL ASSISTANCE AND TRAINING PROGRAMS, AND AN ALMOST EXCLUSIVE FOCUS ON BASIC RESEARCH.

WITH THE PASSAGE OF THE 1988 ANTI-DRUG ABUSE ACT (P.L. 100-690), FEDERAL LEADERSHIP RESPONSIBILITIES HAVE INCREASED DUE TO NEW DATA COLLECTION MANDATES, TECHNICAL ASSISTANCE REQUIREMENTS AND ADDITIONAL TREATMENT OUTCOME STUDIES. THE STATE ARE HOPEFUL THAT AS THE NEW PROVISIONS OF THE 1988 DRUG ACT ARE IMPLEMENTED THE FEDERAL GOVERNMENT, VIA THE ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION, WILL ONCE AGAIN STRIKE A POSITION OF NATIONAL LEADERSHIP IN ASSISTING THE STATES AND LOCAL COMMUNITIES TO EXPAND AND IMPROVE ALCOHOL AND OTHER DRUG ABUSE TREATMENT SERVICES.

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CONTINUING NEED FOR ADDITIONAL FEDERAL RESOURCES FOR ALCOHOL AND OTHER DRUG ABUSE TREATMENT

ACROSS OUR NATION DRUG ABUSE AND ALCOHOL PROBLEMS CONTINUE TO GROW IN MAGNITUDE AND SEVERITY, PARTICULARLY AMONG OUR YOUTH. STATES AND LOCAL COMMUNITIES THROUGHOUT THE COUNTRY HAVE A SIGNIFICANT AND GROWING NEED FOR ADDITIONAL FEDERAL RESOURCES FOR ALCOHOL AND OTHER DRUG ABUSE PREVENTION AND TREATMENT SERVICES.

CURRENTLY THE FEDERAL ALCOHOL, DRUG ABUSE AND MENTAL HEALTH SERVICES (ADMS) BLOCK GRANT PROVIDES LESS THAN ONE-THIRD OF THE MONIES CONTRIBUTED BY STATE AND LOCAL GOVERNMENTS FOR ALCOHOL AND OTHER DRUG SERVICES. LAST YEAR, A TOTAL OF OVER $2.1 BILLION WAS SPENT FOR STATE SUPPORTED ALCOHOL AND OTHER DRUG ABUSE PREVENTION AND TREATMENT SERVICES. SEVENTY-SEVEN (77) PERCENT OF THESE FUNDS WERE DIRECTED TO COMMUNITY BASED TREATMENT SERVICES.

OF THE TOTAL $2.1 BILLION EXPENDED, STATE AND LOCAL FUNDING ACCOUNTED FOR 57.4 PERCENT AND THE ADMS AND ADTR BLOCK GRANTS PROVIDED 16.5 PERCENT OF THE TOTAL. THE REMAINING FUNDS CAME FROM OTHER SOURCES, INCLUDING THIRD-PARTY REIMBURSEMENT AND CLIENT FEES.

WITH THE FUNDING PROVIDED TO THE STATE ALCOHOL AND DRUG ABUSE AGENCIES IN FISCAL YEAR 1988, A TOTAL OF 6,916 ALCOHOL AND OTHER DRUG ABUSE TREATMENT FACILITIES THROUGHOUT THE NATION WERE FUNDED

AND OVER 1,734,000 CLIENTS WERE ADMITTED TO TREATMENT PROGRAMS.

INCREASED FEDERAL APPROPRIATIONS TO THE ALCOHOL, DRUG ABUSE AND MENTAL HEALTH SERVICES BLOCK GRANT ARE URGENTLY NEEDED TO ENABLE THE STATE AND LOCAL COMMUNITIES TO EXPAND PROGRAMMING TO REACH EVEN MORE CHILDREN AND ADULTS, PARTICULARLY THOSE ADDICTED TO CRACK/COCAINE AND TO MAKE MORE TREATMENT SLOTS AVAILABLE TO INTRAVENOUS DRUG ABUSERS TO REDUCE THE ESCALATING AIDS/HIV RATE AMONG THIS POPULATION. THROUGH THE 1988 ANTI-DRUG ABUSE ACT, AN ADDITIONAL $125 MILLION IN FY 1989 BLOCK GRANT FUNDING WAS MADE AVAILABLE TO THE STATES WITH THE STIPULATION THAT ONE-HALF ($62.5 MILLION) BE SPENT FOR TREATMENT OF IV DRUG USERS. THIS AMOUNT WAS VIEWED AS AN INITIAL DOWN PAYMENT TOWARD THE GOAL OF MEETING "TREATMENT ON DEMAND" AS RECOMMENDED BY THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS (AIDS) EPIDEMIC.

CLEARLY THE MEMBERS OF CONGRESS RECOGNIZED THE NEED FOR ADDITIONAL FUNDING FOR ALCOHOL AND OTHER DRUG ABUSE TREATMENT BY THEIR OVERWHELMING PASSAGE OF THE 1988 ANTI-DRUG ABUSE ACT WHICH PROVIDED A FY 1989 ADMS BLOCK GRANT AUTHORIZATION LEVEL OF $1.5 BILLION AND SUCH SUMS AS NECESSARY FOR FISCAL YEARS 1990 AND 1991. IN ADDITION, CONGRESS AGREED TO INCREASE THE PROPORTION OF FEDERAL FUNDING SPENT ON DEMAND REDUCTION ACTIVITIES TO RECTIFY THE PAST INEQUITIES IN PREVENTION AND TREATMENT SPENDING.

STATES EFFECTIVE USE OF THE ALCOHOL, DRUG ABUSE AND MENTAL HEALTH BLOCK GRANT MONIES

ALL STATES STRIVE TO USE THE ADMS BLOCK GRANT FUNDS AS WISELY AND EFFICIENTLY AS POSSIBLE TO IMPLEMENT QUALITY ALCOHOL AND OTHER DRUG ABUSE PREVENTION AND TREATMENT PROGRAMS. WHILE THE INTENT OF THE BLOCK GRANT MECHANISM IS TO PROVIDE STATES AND LOCAL COMMUNITIES WITH THE NEEDED FLEXIBILITY TO TAILOR SERVICES TO MEET THEIR IDENTIFIED NEEDS AND TARGET POPULATIONS, THE FEDERAL BLOCK GRANT LEGISLATION CONTAINS A NUMBER OF "SET ASIDES" MANDATING THE USE OF THE FUNDS IN CERTAIN WAYS, OFTEN AT ODDS WITH STATE DETERMINED PRIORITIES.

ADDITIONALLY, EACH TIME THE BLOCK GRANT PROGRAM HAS BEEN REAUTHORIZED BY CONGRESS, A NUMBER OF CHANGES WERE INSTITUTED THAT AFFECTED THE AMOUNTS EACH STATE RECEIVED, HOW THE FUNDS WERE TO BE EARMARKED AND HOW LONG THE FUNDS WERE AVAILABLE FOR USE BY THE STATES AND LOCAL COMMUNITIES. THIS COUPLED WITH THE YEARLY UNCERTAINTY REGARDING SPECIFIC FEDERAL FUNDING LEVELS, CAUSE THE STATES DIFFICULTY IN PROVIDING UNINTERRUPTED QUALITY TREATMENT SERVICES.

ALL STATES IMPLEMENT A CAREFUL AND DELIBERATE PLANNING PROCESS IN ORDER TO ENSURE THAT MONIES ARE UTILIZED IN A COST EFFECTIVE MANNER WHERE THEY ARE MOST NEEDED - IN MANY STATES THIS PROCESS INVOLVES THE STATE LEGISLATURE'S REVIEW AND APPROVAL OF THE

ALLOCATION OF THESE IMPORTANT RESOURCES, INCLUDING THE CONGRESSIONALLY MANDATED STATE PUBLIC HEARINGS ON THE PROPOSED USE AND DISTRIBUTION OF THE BLOCK GRANT FUNDS. AFTER STATES GET THE NECESSARY AUTHORITY AND FINAL APPROPRIATIONS LEVELS, MOST STATES USE A FAIR AND EQUITABLE COMPETITIVE PROCUREMENT PROCESS TO SELECT COMMUNITY BASED TREATMENT PROVIDERS.

BECAUSE OF THE CONTINUING CRITICISM REGARDING THE STATES' "DRAW DOWN" OF THE ADMS BLOCK GRANT FUNDS, I WOULD LIKE TO CLARIFY THE MANNER IN WHICH STATES ACCESS THESE FUNDS. THE ADMS BLOCK GRANT FUNDS ARE AVAILABLE TO THE STATES ON A DRAW DOWN BASIS THAT PERMITS FUNDS TO BE TAKEN FROM THE FEDERAL TREASURY A MAXIMUM OF ONLY TWO OR THREE DAYS BEFORE A STATE WRITES CHECKS TO REIMBURSE COMMUNITY PROGRAMS FOR SERVICES; ONLY AT THIS TIME DOES THE COMMUNITY PROGRAM EXPENDITURE SHOW AS A DRAW DOWN, I.E., "SPENT" BY THE STATE. IN FACT, THE FUNDS HAVE BEEN ACTUALLY SPENT BY COMMUNITY AGENCIES AS LONG AS SEVERAL (THREE TO FOUR) MONTHS BEFORE THE FEDERAL MONEY IS DRAWN DOWN AND HAVE BEEN LEGALLY OBLIGATED BY THE STATE TO COMMUNITY PROGRAMS AS LONG AS 12 MONTHS PRIOR TO THE DRAW DOWN. THUS, FOR MOST STATES, THE ADMS BLOCK GRANT OPERATES PRIMARILY AS A REIMBURSEMENT MECHANISM.

NEW YORK STATE LAW REQUIRES THE STATE LEGISLATURE TO APPROPRIATE ALL FUNDS UNDER STATE MANAGEMENT, INCLUDING FEDERAL GRANT FUNDS. ONCE THE STATE AGENCIES RECEIVE THEIR GRANT AWARDS AND OBTAIN SPENDING AUTHORITY FROM THE STATE LEGISLATURE, STATE AGENCIES

MUST ENTER INTO CONTRACTS WITH COMMUNITY BASED PROJECTS WHICH ARE SELECTED TO RECEIVE THE FUNDS. STATE DISBURSEMENTS ARE LATER MADE WHEN RECIPIENTS SUBMIT STATE AID VOUCHERS FOR ACTIVITIES WHICH HAVE BEEN COMPLETED AND FOR EXPENDITURES ALREADY MADE. THUS, DRAW DOWNS IN NEW YORK HAVE CONSISTENTLY UNDERSTATED THE LEVEL OF PROGRAM ACTIVITY SINCE THEY OCCUR AS THE FINAL STEP IN THE PROCESS OF TRANSFERRING FEDERAL GRANT FUNDS TO THE STATE AFTER THE ACTIVITIES FOR WHICH THEY ARE INTENDED ARE COMPLETED.

EFFICACY OF ALCOHOL AND OTHER DRUG ABUSE TREATMENT

IN YOUR LETTER INVITING ME TO TESTIFY BEFORE THIS COMMITTEE, MR. CHAIRMAN, YOU HIGHLIGHT THE COMMITTEE'S SPECIAL CONCERN ABOUT THE EFFICACY OF DRUG TREATMENT. YOU ALSO SAY THAT STATISTICS APPEAR TO INDICATE THAT CERTAIN TREATMENT MODALITIES HAVE ENJOYED SOME MEASURED SUCCESS IN TREATING SOME ABUSERS.

AS A MATTER OF FACT, VIRTUALLY ALL STUDIES CONDUCTED OVER THE LAST 15 YEARS SHOW THAT DRUG AND ALCOHOL ABUSE TREATMENT IS EFFECTIVE IN REDUCING SUBSTANCE ABUSE, INCREASING EMPLOYMENT, IMPROVING PSYCHOLOGICAL ADJUSTMENT AND DECREASING CRIMINALITY. AS SUCH, THE EVIDENCE TO SUPPORT PUBLIC EXPENDITURES, INDEED MASSIVELY INCREASED PUBLIC EXPENDITURES, IS OVERWHELMING.

THE LARGEST AND MOST COMPREHENSIVE STUDY OF THE EFFECTIVENESS OF DRUG ABUSE TREATMENT EVER UNDERTAKEN WAS THE TREATMENT OUTCOME

PROSPECTIVE STUDY (TOPS). THE LATEST AND MOST PERSUASIVE EVIDENCE OF THE EFFICACY OF TREATMENT RELYING ON EVIDENCE FROM THIS STUDY WILL BE RELEASED IN A BOOK TO BE PUBLISHED OCTOBER, 1989.

TOPS WAS A MULTI-YEAR STUDY OF PUBLICLY FUNDED DRUG PROGRAMS SUPPORTED BY THE NATIONAL INSTITUTE ON DRUG ABUSE (NIDA) AND CONDUCTED BY A TEAM OF INVESTIGATORS AT THE RESEARCH TRIANGLE INSTITUTE IN NORTH CAROLINA. THE STUDY INVOLVED 10,000 INDIVIDUALS ADMITTED TO 37 SELECTED PROGRAMS IN TEN CITIES ACROSS THE NATION. SPECIFIC TREATMENT MODALITIES EXAMINED WERE METHADONE MAINTENANCE, RESIDENTIAL TREATMENT, AND OUTPATIENT DRUG FREE PROGRAMS. STUDY PARTICIPANTS WERE FOLLOWED FROM ONE MONTH AFTER ADMISSION UNTIL THREE TO FIVE YEARS AFTER TREATMENT WAS COMPLETED.

THE LATEST TOPS FINDINGS ARE EXPECTED TO CONCLUSIVELY DEMONSTRATE THAT TREATMENT IS EFFECTIVE IN ALL THREE MAJOR MODALITIES STUDIED WHICH WILL CONFIRM THE EARLIER FINDINGS OF THE DRUG ABUSE PROGRAM REPORT (DARP), THE FIRST LARGE-SCALE LONGITUDINAL STUDY OF ADMISSIONS TO DRUG TREATMENT SUPPORTED BY NIDA. DARP SHOWED, FOR EXAMPLE, A DRAMATIC DECLINE IN HEROIN USE DURING AND AFTER TREATMENT: A REDUCTION FROM 100% TO 39% IN THE FIRST YEAR AND TO 26% BY THE THIRD YEAR FOR RESIDENTIAL CLIENTS; FROM 100% TO 36% TO 24% FOR METHADONE CLIENTS; AND FROM 100% TO 44% TO 28% FOR OUTPATIENT CLIENTS.

ELIMINATING OR REDUCING DRUG ABUSE AND ASSOCIATED CONSEQUENCES IS THE PRIMARY GOAL OF DRUG ABUSE TREATMENT. ALTHOUGH ABSTINENCE IS DIFFICULT TO ACHIEVE, THE FINDINGS FROM TREATMENT STUDIES SHOW THAT ALL TREATMENT MODALITIES RESULT IN SUBSTANTIAL DECREASES IN OPIOID AND NONOPIOID DRUGS FOR PERSONS WHO REMAIN IN TREATMENT AT LEAST THREE MONTHS.

AS EXPECTED, TREATMENT STUDIES CONSISTENTLY DEMONSTRATE THAT RECURRING DRUG ABUSE TREATMENT IS COMMON FOR MANY INDIVIDUALS. ON AVERAGE, CLIENTS WERE ADMITTED TO TREATMENT FOR THE FIRST TIME AT AGE 24, ABOUT EIGHT YEARS AFTER BECOMING DRUG ABUSERS. THE EXPERIENCE OF CLIENTS AGE 30 AND OLDER WHO ARE IN TREATMENT SUGGESTS THAT THESE INDIVIDUALS MAY SPEND ABOUT 70 WEEKS IN TREATMENT DURING THEIR LIFETIME, AND BE ADMITTED TO TREATMENT FIVE SEPARATE TIMES. AS EXPRESSED BY DR. VINCENT DOLE IN A RECENT ARTICLE CONTAINED IN THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, SPEAKING FROM THE PERSPECTIVE OF HIS LONG ASSOCIATION WITH METHADONE MAINTENANCE TREATMENT, "THE TREATMENT... IS CORRECTIVE BUT NOT CURATIVE FOR SEVERELY ADDICTED PERSONS" IN MANY CASES. THIS APPEARS TO BE TRUE FOR ALL MODALITIES.

NEVERTHELESS, BENEFITS OF REDUCED DRUG ABUSE AND INCREASED PRODUCTIVITY ASSOCIATED WITH TREATMENT JUSTIFY THE TAX DOLLARS SPENT ON OUTPATIENT METHADONE, RESIDENTIAL AND OUTPATIENT DRUG FREE PROGRAMS. IT IS CLEAR THAT THE COST OF TREATMENT IS

SUBSTANTIALLY RECOVERED DURING TREATMENT AND SAVINGS TO SOCIETY AFTER A CLIENT HAS BEEN DISCHARGED REPRESENT FURTHER RETURNS ON THE INVESTMENT.

NASADAD HAS RECENTLY UNDERTAKEN AN EXTENSIVE REVIEW OF LITERATURE PRODUCED OVER THE LAST 15 YEARS WHICH IS SPECIFICALLY CONCERNED WITH THE ISSUES OF TREATMENT EFFICACY. WE ARE EAGER TO SHARE WITH THE COMMITTEE FINDINGS FROM THIS EFFORT AND CAN ALREADY REPORT THAT THE TOPS STUDY CONFIRMS FINDINGS OF THE LARGE BODY OF EVIDENCE ACCUMULATED DURING THE LAST DECADE AND A HALF THAT DRUG ABUSE TREATMENT HAS BEEN EFFECTIVE IN REDUCING DRUG USE, CRIMINAL ACTIVITY, DEMAND FOR SOCIAL SERVICES, AND OTHER NEGATIVE BEHAVIORS. IN ADDITION, TREATMENT HAS INCREASED PRODUCTIVITY, IMPROVED HEALTH, AND HAS BEEN A SIGNIFICANT FACTOR IN PREVENTING THE SPREAD OF AIDS AND HIV INFECTION.

THE EVIDENCE ALSO SHOWS THAT POSITIVE CHANGES IN BEHAVIOR ARE MORE DRAMATIC AFTER LONGER COURSES OF TREATMENT (6 TO 12 MONTHS) THAN CHANGES FOLLOWING BRIEF TREATMENT EXPERIENCES. MUCH REMAINS TO BE LEARNED INCLUDING WHICH SPECIFIC FEATURES OF TREATMENT WORK BEST FOR THE VARIOUS TYPES OF CLIENTS, AND WHAT SPECIFIC CHARACTERISTICS OF CLIENTS, AND NON-TREATMENT FACTORS, INFLUENCE OUTCOMES. THESE CONSIDERATIONS ARE ESPECIALLY IMPORTANT IN VIEW OF THE CHANGING NATURE OF SUBSTANCE ABUSE WHICH NOW INVOLVES YOUNGER PEOPLE THAN EVER BEFORE, DRAMATICALLY INCREASED INCIDENCE OF MULTIPLE DRUG ABUSE PATTERNS AND THE EMERGENCE OF COCAINE AS

THE PREDOMINANT DRUG OF ABUSE. THESE FACTORS COMBINED WITH THE INCREASINGLY SEVERE HEALTH AND MENTAL HEALTH PROBLEMS ASSOCIATED WITH ADDICTION REQUIRE MORE CAREFUL MATCHING OF PARTICULAR TREATMENTS WITH SPECIFIC TYPES OF CLIENTS NOW AND FOR THE FUTURE.

CONCLUSION

PERHAPS THE CLEAREST MESSAGE RESULTING FROM OUR ANALYSIS TO DATE IS THAT WITH ONLY ABOUT 10% OF THE ESTIMATED 1.5 MILLION INTRAVENOUS DRUG ABUSERS ENTERING TREATMENT IN ANY GIVEN YEAR, WE URGENTLY NEED ADDITIONAL FUNDS, MORE AND BETTER FACILITIES, IMPROVED OUTREACH, RESEARCH ON THE MOST EFFECTIVE METHODS OF TREATMENT, A BETTER INFORMED PUBLIC, AND, OVERALL, A RENEWED COMMITMENT TO TREATMENT AS A WISE AND PRUDENT PUBLIC INVESTMENT. THE DISASTROUS EFFECTS OF REDUCED FEDERAL SUPPORT BETWEEN 1982 AND 1988 ARE IN EVIDENCE ALL ACROSS THE COUNTRY AND MUST NOW BE ADDRESSED IF WE ARE TO REVERSE THE VICIOUS AND PERVASIVE CATASTROPHE ASSOCIATED WITH ALCOHOL AND OTHER DRUG ABUSE IN OUR SOCIETY.

Statement of Commissioner Thomas A. Coughlin III,
New York State Department of Correctional Services

Representative Rangel, thank-you for the opportunity to appear this morning before the Select Committee on Narcotics Abuse and Control.

All of us know we are in a war – against drugs.

What doesn't get sufficient notice sometimes is the fact that, like it or not ... despite the billions we have spent ... we are losing that war.

We must explore new avenues to address drug addiction and recovery, or we will continue the revolving door of arrest, incarceration and parole, to surely be followed by re-arrest.

In New York, we were among the states to pioneer the concept of *shock incarceration*. We are today on the threshold of instituting yet another unique approach to drug treatment in prison, tied to aftercare on parole. It is these programs that I want to discuss this morning.

But I will begin with a caveat: There are no perfect solutions, just as there are no instant answers. There are only appropriate punishments and alternatives that we haven't tried yet.

I remember attending the first inmate graduation from *shock incarceration* – boot camp – a few years ago. I watched as tears streamed down the face of the platoon salutatorian. I listened as his voice broke, while extolling the virtues of shock and all it had meant to him.

He's back in jail. And I ask this select committee to remember that – every time we try a new program, or a new approach – there will be failures. But we should look beyond the anecdotal failures and focus our efforts upon our thousands of successes ... and what works.

Because I believe our role as public servants requires us to examine and maybe even try every sound idea that we think might turn things around, and help us to start winning this war.

Because what is at stake is our future. And what we face losing is America's most precious resource – our children and our young people.

Let me begin with our experience with shock.

Our early experience with shock has shown us two things that suggest we might be on the right track:

- Inmates who complete shock return at a rate of 17% compared to 25% among all inmates. That is significant because each 100 successful shock releases saves taxpayers $1.5 million.
- Inmates who complete shock return at the same 17-19% as do inmates who were eligible for it but chose not to participate. That means the return rate for inmates who are in shock for only six months is the same as for those who spend an average of an additional eight months in prison.

The purpose of prison has traditionally been the secure confinement, rehabilitation and segregation of felons.

That thinking has changed in New York State. We do not believe in *re*habilitation.

Because one definition of rehabilitation is "to restore and to improve its original state."

Why would you want to use prison to turn out a better class of drug users and dealers?

Governor Mario M. Cuomo endorses that concept of habilitation.

Most people in prison were never socialized in the first place. That ignorance of how to live in our society contributed to their criminal activity.

Our goal becomes one of habilitation. Now, we are attempting to showcase that philosophy.

The six-month shock regimen includes more than just the 500 hours of physical training plus drill and ceremony that has led to the media dubbing it a "boot camp."

It also includes 546 hours of the therapeutic approach to treating addiction, based on the *Network* program and in Alcoholics Anonymous' *12 Steps to Recovery*. It also includes at least 260 mandatory hours of academic education, and it also includes 630 hours of hard labor, working on facility projects, community service work and projects in conjunction with the Department of Environmental Conservation.

Of nine shock-type programs surveyed, New

Statement of Commissioner Thomas A. Coughlin III,
New York State Department of Correctional Services

...e where:

York's la... to undergo one month of

- Staff ...ng before inmates arrive, so shocker...intendents and clerks alike, that m... the content and goals of the are av...
  progr...udes an intensive therapeutic
- The p...ach to habilitation, and
  comm...s undergo a full year of
- Inmat... follow-up.
  inten...cessful completion of the

We b...esults in inmates becoming six-month...ay get out of prison as much better pe... years early. Failure means as two a... in prison.
serving a ...eir's. As attractive as that may

But the ...cent have found the regimen sound to s...n with the carrot of early too dema... release.

Many ...y chosen to leave and to complete ...ce in a traditional prison.

Our las... show that of the inmates eligible fo...rceration, 44 percent either did not ap...rogram, or applied and were found med...chologically unfit.

Through ...his year, 5,230 inmates had been scree...program, 1,951 have entered it and 831 ...ted; 597 remain active in the program, w...ve transferred out, including 320 "wash...173 have left at their own request.

But for ... volunteer, successful participation in ... is defined as:

- Learnin... without committing crimes against ...eir property;
- Having ...spect for yourself to take control ... responsible for, your own actions;
- Discipli...lf to seek realistic goals through ...onest efforts, and
- Develop...lly-acceptable tools to succeed; ... work ethics, job skills and whatever ... or counseling might be needed ...ual situation.

Most inm... possess nor respect such abilities.

So our goal is to offer to habilitate them:

- In a program running from 5:30 a.m. to 9:30 p.m.
- Six days a week.
- With a full three hours of free time -- each and every Sunday.

The treatment component, which differentiates our program from most others, is extensive.

Governor Cuomo does not believe we can turn someone's life around simply by making them do push-ups, march in formation, or simply by taking orders.

The strict physical regimen is a pivotal tool in teaching discipline and respect for authority.

It is also an excellent means of challenging individuals, as well as teaching them about teamwork and getting along with others.

But of equal importance and weight in our program are the components that deal with education, professional and peer counseling, plus drug and alcohol therapy.

Network therapeutic community meetings, with staff and inmates working in sometimes confrontational dialogues, are held for one hour each week day. There are also sessions designed to teach decision-making in socially acceptable ways, which run for two hours each week. For four hours per week, group meetings focus on problem-solving, confrontation and conflict resolution.

Here's how one inmate described *Network* in a letter to his family: "Here they also have a thing called the Network program. You might have heard about it. It helps you learn more about yourself and understand different things better."

Individual counseling, as required, takes up another hour per month – more if required.

Pre-release programs, designed to help inmates make the transition from prison to parole, require two hours each week.

The daily program at each facility includes two to three hours of physical training. That includes military-style drills, calisthenics and a 2-3 mile run. For seven hours each weekday, inmates are involved in labor-intensive work projects.

They perform community service projects in neighboring towns and villages; they also cut trees

nd clear brush for the state Department of Environmental Conservation; they work on onstruction and maintenance at the camp itself.

A full day each week is devoted to education, ncluding high school equivalency diploma courses, emedial education and other academics. Education courses are also held week nights.

It is the combination of these programs that we elieve offers young offenders the chance to get heir heads on straight and their lives in order. Traditionally, we sent felons to prison as unishment. Now we send some young offenders to hock incarceration, in hopes of helping them ecome good citizens.

There are weekly assessments made of each nmate in each program category, and monthly eviews are completed by a committee that includes Division of Parole as well as by Correctional Services' personnel at the shock facilities.

Eligibility requirements are different for inmates up to age 26, as opposed to those from age 26 hrough age 29, the cutoff for participation in the rogram. New York is one of only two staes in the ation where the Department of Corrections elects among eligible inmates for participation in he shock program.

For inmates who are less than 26 years of age, they re eligible if:

- They are physically and mentally qualified;
- This is their first sentence to State prison;
- They are within three years of parole eligibility;
- They are not serving a sentence for a violent offense, such as murder, manslaughter or rape.

For inmates over age 26 but under 30, the rules re the same with these added restrictions:

- They cannot have ever been convicted of a crime that would keep them out of shock. (Inmates imprisoned for drug possession, for example, would be excluded if they had previously been convicted of a violent crime, even if they received a sentence of local jail time or probation.)
- The sentencing judge must not oppose their participation in shock.
- They must serve at least one year, including the six months in shock.

Throughout the nation, most other shock programs are contiguous with a medium- or maximum-security facility.

In New York, we are devoting entire, separate facilities to this program, with every aspect of their operations focused on, and supportive of, the shock program.

Each is located in a rural setting in upstate New York, with plenty of room for their dormitory-style housing units.

The rural setting is advantageous. The noise of marching and cadence calling, as well as physical training, does not disturb neighbors.

The 250-bed Monterey Shock Incarceration Facility opened on September 10, 1987, in Schuyler County. Its first platoon graduated March 8, 1988.

The 250-bed Summit Shock Incarceration Facility, in Schoharie County, began accepting males on April 12, 1988. Females entered the program on Dec. 12. Summit's first platoon of females graduated last month.

In April of 1989, the State's third Shock prison, also a 250-bed facility, opened at Moriah in Essex County. The first graduation at this facility for males will be on September 21, 1989.

On June 22, just about one month ago, a graduation of sorts was held at the State's fourth 250-bed shock camp. On that date, staff at the Butler Shock Incarceration Facility in Wayne County completed one month of training in advance of receiving their first inmates on June 26. As at the three earlier camps, Butler's staff spent a month undergoing training along the lines of what inmates will experience when they enter the program.

Staff inform inmates of the purpose and objectives of the program, describe a typical day and respond to questions. Eligible inmates are then offered the opportunity to volunteer for it. Upon acceptance, inmates receive a two-week orientation before the actual program gets underway. They are currently screened at our reception and classification centers.

That will change next month when the 750-bed Lakeview Shock Incarceration Facility opens at Brocton in Chautauqua County, making it the largest "boot camp-style" prison in the nation.

After Lakeview opens, reception centers will

transfer to Lakeview all inmates who are shock-eligible, whether or not they volunteer for it.

At Lakeview, inmates will be advised of the program. Those who opt not to participate will be transferred to traditional prisons.

Those who choose to volunteer will either join a platoon right at Lakeview, or be transferred to a unit at one of the four smaller shock facilities.

There were downsides to the program. I think they have been rectified as shock becomes a more familiar operation within our system.

Not surprisingly, those downsides concerned staff and inmates.

Traditionally, our camps like Monterey and Summit were havens for senior officers.

The camps housed inmates on their way out of the system, whose good institutional records allowed their transfers to these minimum-security facilities.

They were minimum risk inmates who wanted to do their time quietly without creating any problems: they knew incidents would land them back in a higher-security institution.

Those same officers today are faced with street-wise young offenders who are just entering the system, and have never seen the inside of a maximum-security prison.

Suddenly, these officers are seeing a flip-flop, where they are on the front end of the system.

With some of that older staff transferring out, they were replaced by younger officers, many of whom lacked the military back ground needed for the boot camp aspect of shock.

To help overcome that situation, we mandate four weeks of training for staff, to show them exactly what is expected in both the boot camp and programmatic sides of shock incarceration.

For inmates, many are opting not to volunteer for the program, because they think it is too difficult.

But inmates who have entered the program have had positive things to say about it:

"I want to say that this is a very positive program and that I am sure that it is going to help a lot of inmates that otherwise would've never had the chance."

"I think zero week (the first week of training) was the very hardest week of my life. Especially the jogging - it was rough on me."

"I think that shock will make me a better man and teach me how to deal with society and teach me a lot of discipline and responsibility. I think that the people that I hurt, when I go home, will be happy to see the change and will be happy of the man that shock has made of me, and not the man that I was before I came to jail."

Another inmate wrote, "I thought zero week was Hell and I ain't going to lie about it."

Parole staff begins their planning the day inmates arrive at the camp and begin that "zero week." As part of the shock program, Governor Cuomo mandated that Parole follow inmates closely upon release to see how they perform.

Parole writes a treatment plan and prepares a report to the parole field office which will supervise the inmate upon release.

Parole officers in the field developed an "after shock" program that includes individual as well as group supervision.

Caseloads are set at 30 parolees per parole officer. Parolees must meet with the officer twice weekly in their first three months after release, then once a week for the next three months.

During those first six months of parole, the meetings with parole continue the decision-making and conflict-resolution counseling begun in shock.

Parole monitors the inmate by making two home visits per month, ensuring the inmate retains full-time employment, or enrolls in an education or drug treatment program as warranted.

For the balance of the inmate's parole, the 30-to-1 ratio is maintained, but group sessions are thereafter run by counseling and therapy groups with mandatory attendance on the inmate's part.

So what does it all cost? The camps are designed to be operated for one year housing 500 inmates - 250 inmates in each six-month program - with a total budget of $5.2 million and a staff of 142. That's $9,000 to house an inmate per year, versus the systemwide cost of $20,000. By comparison, a 250-bed minimum-security camp would have 127 employees and a budget of approximately $4.9 million. Each are self-contained minimum-security facilities.

We must also realize that the savings of up to 30 months of incarceration for each successful participant is a sizable savings to taxpayers.

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New York State Department of Correctional Services

Diverting young offenders from criminal activity in a cost-efficient manner provides an even better return for the people footing the bill – the New York taxpayers.

But the biggest return to society, if we are successful, will come in the fact that, hopefully, these offenders will not return to their criminal ways and wind up back in prison.

We believe we are on the right track. Governor Cuomo is committed in his belief that punishment need not always take the form of incarceration.

Any state can build its way out of prison crowding by adding cells – at the cost of less money being available for tax cuts, highways, education and other programs.

Governor Cuomo has proposed many alternatives to incarceration, and shock is only one of them.

Young offenders can be diverted from criminal activity, if we offer them the chance of a productive life – and if they want to take advantage of it.

Governor Cuomo wants to reduce recidivism, not just cut the level of prison crowding. We hope shock will continue to help in that effort.

Our efforts to battle addiction does not stop with shock. We begin a major program later this year that builds upon what we have learned from shock and through 10 years of treating inmate addicts.

Six 200-bed Alcohol and Substance Abuse Treatment (ASAT) Annexes were authorized on July 11 when Governor Cuomo signed the *Omnibus Criminal Justice Law of 1989*. The annexes will be unique in two ways:

- This Department will provide security, administration and support personnel at each Annex, but outside non-profit organizations will be contracted with to come inside these prisons to provide residential drug treatment.
- Those providers will be required to sign contracts with the Division of Parole, guaranteeing each inmate an appropriate drug treatment slot in their county of commitment upon parole release.

Full implementation of Governor Cuomo's drug program will bring the number of new drug treatment beds to 2,150. It includes, in addition to the six 200-bed annexes:

- Authorization for a seventh Annex if the number of new prison commitments warrants it, and both the Governor and Legislature agree to appropriate funds.
- Appropriated funding for a 750-bed medium-security prison in which all inmates will be in the ASAT program administered by Departmental staff. We believe this will be the largest single prison in the nation dedicated to addressing drug abuse among felons. It will cost $65 million to build and $17 million a year to operate with 400 workers.

This addiction recovery program is intended to break the cycle of abuse by mandating a continuum of treatment: No longer will inmates receive drug treatment and enter recovery in prison, only to relapse on the street – in part because no one is guaranteeing them a treatment slot.

If parolees continue in recovery programs, they will not be committing crimes against our citizens to obtain drugs. Our taxpayers will not be spending $100,000 to build a cell for parolees to return to, and $25,000 a year to house them. The money can be spent instead on social programs, highways and bridges, tax cuts and to address other needs. But the process begins with breaking the drug cycle, in order for us to invest in the future of the recovering addict who has done time, as well as in the future for us all.

The *Omnibus Criminal Justice Bill of 1989*, among other initiatives, authorized the construction of 5,400 new prison beds – with 1,950 of them, or 43% of the expansion, earmarked for residential drug treatment. In signing it, Governor Cuomo noted that, "The police officers on the streets are making more and better arrests while the courts are making more and longer commitments to State prisons ... (this law) will allow us to build more cells and enhances our chances of deterring future crimes by the people who fill them. It is another major component of our effort to take back the streets."

The ASAT Annexes will address the two overwhelming commonalties among inmates: More than 70 percent admit to having abused drugs on the outside, while 80 percent lack the high school degree required to hold even some entry level employment.

Roughly 20 percent of inmates who successfully complete residential ASAT programs return to

prison, against a return rate of upwards of 30 percent among non-participants. Only 17 percent of inmates earning high school equivalency degrees return, compared to 25 percent among those who don't.

All 57 State prisons offer ASAT programs, while eight facilities also offer residential drug treatment, lasting 3-9 months, such as that to be offered in the annexes. The existing ASAT program costs $4.6 million annually, and serves 12,000 offenders a year.

200-bed ASAT Annexes will be built within the perimeters of the Marcy medium-security prison and the Lakeview Shock Incarceration Facility, one adjacent to the Butler facility, while the remainder will be free-standing units in Brasher, Chateaugay and Johnstown, distant from any other prisons. Each will cost $20 million to build and will cost $5 million a year to operate with 140 employees.

The therapeutic community approach to ASAT – in place at existing residential programs – will be duplicated at the Annexes. Inmates will be involved in intensive group therapy and individual counseling, as well as in the *Network* program. Academic education, to address the second greatest need among inmates, will also be compulsory.

Inmates in the program will be those within two years of parole eligibility whose prison adjustment and program participation, plus their crime of commitment, allow them the privilege of participating in Temporary Release Programs.

The organization providing ASAT will, as inmates develop a proven record of addressing their addiction, recommend that inmates be temporarily released to the drug treatment program that the provider believes will meet the need of the individual inmate upon parole – while allowing the provider to oversee the inmates readjustment to society prior to that parole release.

It should be clearly understood that inmates will be on temporary release: Such status is granted at my sole discretion, and I can revoke it at any time, and order the inmate returned to prison.

Unlike shock, inmates will have no choice as to whether they are sent to the Annexes for treatment. And they won't get out of prison one day early for successfully participating in a recovery program.

What they will have received, however, is a better chance for success on the street. That's their carrot.

That is all – and everything – that we must provide, if we are to break the cycle of drug abuse and crime among offenders.

CONGRESSMAN LAWRENCE COUGHLIN

VICE-CHAIRMAN HOUSE SELECT NARCOTICS COMMITTEE

HEARING ON NATIONAL CRISIS IN DRUG ABUSE TREATMENT

JULY 25, 1989

THANK YOU, MR. CHAIRMAN. I AM PLEASED TO JOIN YOU IN WELCOMING OUR WITNESSES TO TODAY'S TREATMENT HEARING AND I LOOK FORWARD TO THEIR TESTIMONY.

I BELIEVE THAT THE BEST HOPE IN COMBATTING DRUGS IS TO REDUCE DEMAND THROUGH EDUCATION. WE MUST TEACH OUR YOUTH THAT USING DRUGS IS A RISK NEVER WORTH TAKING. WE MUST GET TO THEM BEFORE THEY HAVE TRIED DRUGS, BEFORE THEY HAVE BECOME ADDICTED.

NONETHELESS, WE MUST NOT FORGET ABOUT THOSE WHO HAVE ALREADY MADE THAT MISTAKE AND HAVE BECOME ADDICTED TO DANGEROUS ILLEGAL DRUGS. THEIR PLIGHT IS A TRAGEDY FOR THEMSELVES AND THEIR FAMILIES. THEY DESERVE A SECOND CHANCE. THOSE WHO HAVE THE WILL TO FIGHT THEIR ADDICTION MUST RECEIVE THE TREATMENT AND REHABILITATION THEY REQUIRE.

HOWEVER, WHAT CONCERNS ME GREATLY IS THAT WE STILL ARE NOT SURE WHAT WORKS IN TREATING ADDICTS OF MANY DRUGS, INCLUDING CRACK COCAINE. WE WILL BE LOOKING TO TODAY'S WITNESSES TO GIVE US GUIDANCE IN THIS AREA, AND PERHAPS TO RECOMMEND WHERE MORE RESEARCH IS NEEDED.

I LOOK FORWARD TO TODAY'S DISCUSSION. THANK YOU, MR. CHAIRMAN.

Advancing psychology as a science, a profession, and as a means of promoting human welfare

TESTIMONY OF

THE AMERICAN PSYCHOLOGICAL ASSOCIATION

FOR THE HEARING RECORD OF THE

HOUSE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

HEARING ON THE NATIONAL CRISIS IN DRUG TREATMENT

JULY 25 AND AUGUST 2, 1989

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The American Psychological Association (APA), the leading scientific and professional society representing over 90,000 clinicians, researchers, educators, consultants and students, is pleased to have this opportunity to submit testimony for the Select Committee's Hearing on Drug Treatment Programs. Psychology plays an integral role in drug abuse treatment, rehabilitation and prevention. Every day our members working with drug and alcohol dependant patients see the devastating toll this problem takes on individual mental health, family structure and society as a whole.

The APA applauds the Select Committee for taking the lead in redirecting our policy makers' attention on "demand-side" issues of drug abuse. Psychologists and other health care professionals involved in the treatment of individuals with drug abuse problems have long been concerned with the lack of focus on and funding for drug treatment and prevention programs. We believe that with the Committee's leadership, that trend will shift to more awareness of the need to address the individual and societal problems that cause people to turn to alcohol and drugs. We are also hopeful that there will be in increase in services that can curtail or prevent drug abuse.

Psychologists, as professionals with extensive training in human behavior, have much to offer in the delivery of effective treatment services as well as drug abuse research and education. This testimony will reiterate the scope of the drug abuse problem in America; identify the need for drug treatment and prevention programs; and will summarize current findings regarding drug abuse treatment and prevention and make recommendations for the future.

II. THE NEED FOR INCREASED EMPHASIS ON DRUG TREATMENT AND PREVENTION PROGRAMS

A. The Problem and Costs to Society

Every day we are reminded of the pervasiveness and severity of the drug abuse problem in the United States. Our neighborhoods are becoming war zones, heavy addiction is on the rise and it seems as though current anti-drug policies are not making enough of an impact on the problem. A 1985 survey found that 23 million Americans had used an illegal drug in the past month and that 6.5 million were severely dependent on heroin, other opiates, amphetamines, and cocaine. Nearly 24% of employed males aged 18-24 and 21% aged 25-34 use marijuana at least once a month (NIDA, 1985). In 1987, 42% of high school seniors reported using an illicit drug in the past year. Over 10% had used cocaine in the past year and over 4% had used cocaine in the past month (NIDA, 1987).

A 1989 household survey reveals that while casual drug use may be declining somewhat, heavy use of drugs such as crack and cocaine is on the rise. Furthermore, the survey shows that women are now more likely to use crack/cocaine and even heroin (NIDA, 1989). Until recently, heavy drug use was concentrated among males. The recent Washington Post profile of Dooney

Waters, the 6-year old boy who spent his early childhood living in a crack house with his drug dependent mother, illustrates the tragic family consequences of the current crack/cocaine market. Children who are repeatedly exposed to drugs and violence suffer psychological trauma and often exhibit symptoms of introverted behavior, phobias, nightmares, violent outbursts, diminished expectations for the future, hyperactivity or extreme listlessness and an inability to trust others or form close relationships.

Too little attention is paid to the effects of drug abuse on the health and well-being of our children. Repeated exposure to family drug abuse undoubtedly has long-term effects associated with juvenile delinquency, school drop-outs, run aways and drug abuse. One study of adolescents enrolled in residential drug treatment centers found that a majority of the participants reported family alcohol or drug abuse. These children most often came from single parent homes and majority had been arrested at least once in the past year (Cator Report 1987).

Heavy drug use among children and adolescents remains high. (NIDA, 1989). As stated previously, over 42% of the students surveyed had used an illicit drug at least once in the past year. Furthermore, nearly 5% reported using one or more illicit drugs on a daily basis during the prior month. These patterns suggest that many adolescents are past the "experimental" stage of drug use and that many will or do suffer from serious physical, mental, and/or social effects (Radhert, 1988). Children are especially vulnerable and are all too frequently the victims of the direct and indirect harm caused by drug abuse.

There is no question as to the link between drug abuse and crime. Current statistics indicate that approximately three-quarters of arrested individuals in major cities tested positive for illegal drugs. Up to one-half of all felony indictments in major cities involve violations of drug laws and it is estimated that 70% of all violent crime in the U.S. is drug-related. (White House Conference on Drug Abuse, 1988).

Drug abuse also puts enormous pressure on our health care delivery systems. Between 1985 and 1988, cocaine-related emergency room admissions reported in 21 major cities increased 227%. In 1986, emergency rooms reported 120,000 drug abuse episodes, over 10% involving 10 to 17 year olds. (NIDA 1989).

Finally, we cannot ignore the economic impact associated with drug abuse in the workplace. One study on this issue suggests that drug users are 3.6 times more likely to be involved in plant accidents and 2.5 times more likely to require absences lasting more than a week as compared to workers who do not use drugs or alcohol and function at about 67% of their work potential (Cohen, 1983). It is estimated that the annual cost to society of drug and alcohol abuse will reach $229 billion in 1990 (The Robert Woods Foundation, 1989). These costs include diminished workforce productivity, increased demands on health care, law enforcement, judicial, and corrections systems. Other studies have estimated that alcoholism alone currently costs over $100 billion per year, mostly due to lost productivity. Many believe that substance abuse

is the Nation's number one problem in terms of costs to the economy (Holder, 1987)

B. Comment on the Factors Associated with Drug Abuse

A wide variety of factors contribute to drug abuse including psychosocial influences such as poverty, peer pressure, work- or family-related stress, divorce, absentee parents, child abuse and neglect. An inextricable component is individual mental health. In some instances drug abuse represents an attempt at self-medication for depression, anxiety or other psychological disorders (O'Brien, et al., 1984). The authors of several articles and studies on drug dependency have noted "...the high degree of psychopathology displayed by opiate addicts and that use of illicit substances frequently occurs in response to psychiatric symptoms" (O'Brien et al., 1984).

A majority of drug addiction cases are associated with some form of psychological disorder. Recent studies indicate that the types of psychological problems observed with addicts are similar to conditions which are often treated with psychotherapy when they occur in non-addict populations (Rounsaville, 1981). The National Institute on Drug Abuse (NIDA) reports that one-half to two-thirds of all drug addiction is linked to individual depression (Ginzburg, 1988).

There is a very high incidence of delinquency among adolescent drug users. Evidence suggests that efforts to prevent adolescent drug abuse and chronic serious delinquency should target the same factors (Hawkins, 1987). The authors of a recent study of adolescent drug use found a significant relationship between early drug usage and several scores reflecting maladjustment, including antisocial behavior, coercive behavior with family members, self-esteem, and depression (Dishion, 1988). This data points to the special need for early diagnosis, treatment, and prevention efforts tailored to high risk youth and their families.

III. CURRENT RESEARCH ON EFFECTIVENESS OF TREATMENT AND PREVENTION OF DRUG ABUSE

A. Treatment

There now exists a large body of research that provides convincing evidence that drug abuse treatment works. Two notable large scale research projects established to evaluate the effectiveness of existing treatment programs are the Treatment Outcome Prospective Study (TOPS) a NIDA supported study using treatment data from 1979 to 1981 and the Drug Abuse Reporting Program (DARP) established by NIDA in 1969. TOPS and DARP are longitudinal, multidimensional programs representing a turning point in state-of-the-art drug treatment outcome studies. Several evaluations written based on TOPS and DARP data conclude that almost all forms of drug abuse treatment are effective in producing significant improvements in reducing use of illicit drugs,

reducing criminality, improving employment and social productivity and improving mental health (Simpson, 1984; Hubbard, 1984). For example, one evaluation of DARP revealed that outcomes from therapeutic communities and outpatient drug-free programs were quite favorable. Of all subjects, 43.6% had favorable outcomes as characterized by drug abstinence and little or no criminality; 29% had moderately favorable outcomes, characterized by moderate drug use, moderate unemployment and by a substantial degree of return to treatment (Cross, 1988). In addition, smaller studies such as that summarized in the CATOR Report of 1988 also report favorable results of various treatment programs (CATOR 1988 Report). Furthermore, based on current literature and data, NIDA maintains that individuals in treatment programs across the board, show significantly improved behaviors consequent to leaving treatment (NIDA, 1988).

The four major treatment programs commonly recognized in the health community and which are the subject of treatment evaluation studies are 1) Therapeutic Communities; 2) Drug-free outpatient settings; 3) Methadone Maintenance; and 4) Detoxification. NIDA reports that studies show in general, each has yielded favorable results. This is true especially when the treatment includes drug counseling or psychotherapy as part of its overall approach (O'Brien, 1984).

Therapeutic communities are full-time drug-free residential programs which are highly organized and provide, for example, peer support and confrontation. Outcome research indicates that this mode of treatment is effective as measured by decrease in drug use, criminality and prosocial behavior. Drug-free Treatment encompasses a wide variety of treatment modalities including self-help groups and psychotherapy. Methadone maintenance involves replacing street heroin with methadone, a synthetic opiate that allows the client to stabilize and through counseling and education, explore options for curbing drug dependency. Finally, detoxification is a method intended to help achieve abstinence by prescribing, under medical supervision, gradual decreases in doses of methadone. Both methadone maintenance and detoxification may also involve other treatment modalities such as drug counseling or psychotherapy and all programs except those that are residential may incorporate a combination of treatment modalities in an inpatient or outpatient setting.

In each of these programs, success is measured by abstinence or decrease in drug use, decreased criminal activity and increased productivity. There are certain factors which seem to enhance the effectiveness of treatment. One such factor, an important predictor of successful treatment, is the inclusion of some form of drug counseling, or group, individual or family therapy. Most completed studies to date suggest that treatment success is significantly improved when comprehensive therapy is included in the treatment program (O'Brien, 1984).

Length of stay in a treatment program is also considered to be an important factor in treatment efficacy. Studies evaluating therapeutic communities show better results for individuals who spend several months in the program and

striking improvements for those who finish the program (DeLeon, 1984). Long-term programs (three months or more) generally have much lower relapse rates than shorter programs. In general, individuals in longer term programs experience less relapse and greater recovery rates (Simpson, 1985; McAuliffe, 1985).

Patient-treatment matching is commanding more attention from the treatment community especially in light of the increasing variety of treatment programs. Furthermore, individuals in drug treatment often have a multitude of problems which points to the need for comprehensive assessment and treatment matching. Matching a patient's specific needs to treatment components enhances treatment efficacy and helps researchers better understand the complex nature of substance abuse. Studies on the effectiveness of alcohol treatment have demonstrated the positive effects of patient-treatment matching. In one study the overall outcome of the matched patients was 19% better than that of a control group (McLellan, 1987).

B. Prevention

The issue of prevention and early intervention deserves special attention. Until recently, prevention efforts have been overlooked and may well be one of our most effective, cost-efficient tools for fighting substance abuse. Prevention and early intervention is especially significant with children and adolescents. As mentioned previously, children are frequently the direct and indirect victims of substance abuse. It is found that many children who enroll in drug treatment programs grew up with family members who also had substance abuse problems.

The data on frequent drug use among adolescents are staggering. According to the 1988 NIDA survey, a quarter (1/4) of a billion youngsters age 12 to 17 were currently using crack or some other form of cocaine when responding in 1988 (NIDA, 1989). The frequency of drug use among this population is extreme, but may well underestimate the problem because of the difficulty of obtaining data on runaways, drop-outs and the homeless, all of whom are at-risk for drug abuse.

A key to any successful prevention effort is getting accurate information to those most at risk. This is especially important in light of the growing popularity of crack and other forms of cocaine which are highly addictive, cause severe physical and psychological problems and are subject to many misconceptions that require increased emphasis on drug education (NIDA, 1986). It is believed that the most promising programs are those initiated during the early adolescent years which have been identified as the first risk period for the "gateway" drugs of tobacco, alcohol and marijuana. These programs focus on the delaying the use or abuse of any of the "gateway" drugs (Pentz, et al., 1989).

School-based programs have been found to be effective in preventing future drug use. The programs studied include cognitive models which increase

students' knowledge of the pharmacological effects and physical and social hazards of abuse on mold attitudes and beliefs supportive of drug abstinence; affective and interpersonal programs which strengthen the child's emotional and psychological resources by improving self-concept and social and psychological development and adjustment; behavioral programs which use instruction, role playing, feedback, and reinforcement to increase resistance to social pressures; environmental programs designed to establish and enforce tougher school drug policies and coordinate school prevention efforts and special programming; and therapeutic models which focus on early identification, referral and counseling for students (Bukoski, 1985). Unfortunately, there is a paucity of concrete data on the effectiveness of drug prevention and intervention programs however, the prevention studies that have been completed indicate substantial positive influence on future drug resistance (Pentz, 1989; Tobler, 1986). Prevention programs take many forms and there is a concensus among experts that any prevention efforts must take a comprehensive approach. A sound prevention program should include mass-media campaigns, community-based programs, education of parents, school-based programs and health policy reforms designed to change attitudes and behaviors about drug abuse (Pentz, 1989).

C. Early Intervention

Implicit in any discussion of treatment and prevention is the issue of early intervention. Intervention concentrates on the identification of persons whose behavior puts them at risk drug abuse and persons in the early stages of drug use. The purpose of intervention is to reverse the early stages of dysfunction of the individuals or groups at risk. Components of a comprehensive intervention strategy should include the training of primary health care professionals to recognize drug related problems; screening for early identification of drug abuse; and intervention and assistance through employee assistance plans (EAPs) or other comprehensive drug abuse programs (Second Triennial Report to Congress, 1987).

There has been an encouraging trend toward early intervention and treatment among adolescents who, as mentioned previously, are entering the first high-risk stage for substance abuse. Identification of those abusing alcohol and drugs is being made an earlier stage of involvement by a wide range of professionals and agencies including teachers and school administrators, juvenile justice system officials, and therapists and counselors. Additionally, more attention should be placed on the diagnostic or assessment process for this population. The nature of drug abuse is changing and adolescent care should not be based solely on adult models. Assessments will be needed to pinpoint the actual problems that may be concomitant with drug abuse and will therefore require the development more detailed and multifaced procedures in order to ensure the most effective course of treatment (Winters, 1988).

Not only have substance abuse treatment, intervention and prevention programs proven effective in improving the lives of millions of at-risk or chemically dependent individuals and their families, substance abuse treatment and

prevention programs are also defensible on the basis of economic benefit to society. Treatment and prevention result in increased worker productivity, and decreased strain on our judicial and correctional systems not to mention substantial savings in health care costs (Simpson, 1988). A 1984 review of outcome studies concludes that "Treatment for alcohol and other substance abuse appears to have an extremely significant potential for economic payback to local state and federal governments, insurance providers, corrections agencies, private industry, and, of course, patients and their families (Holder and Blose, 1986; 1986: Hoffman, 1984: p.83). When compared to the cost of enforcement activities such as incarceration of drug law offenders it makes one wonder why we have spent so little public money on treatment and prevention and so much on enforcement and interdiction. For example, the annual cost for each prisoner in a maximum security facility is $30,000 and the cost for a comprehensive substance abuse treatment program often is as little as $4,000.

V.RECOMMENDATIONS

1. LONG-TERM STRATEGY: We are well aware that there are no quick fixes for our Nation's growing drug abuse crisis. More stringent enforcement and tougher penalties for drug activity have had some sucess but most will agree enforcement is an inadequate long-term solution to drug abuse. We encourage policy makers to set-long term goals for reducing drug dependency and develop a coordinated intragovernmental strategy for reaching those goals. Such a plan should be developed in close consultation with mental health and health care professionals working as providers, educators and researchers.

2 .RATIONAL FUNDING: More resources should be concentrated on "demand reduction" programs. While there has been a recent shift in the past practice of spending billions more on "supply-reduction" programs of law enforcement and interdiction, the Administration has failed to include adequate funding for drug rehabilitation and treatment, and Congress has failed to fully fund treatment programs authorized under current law. We urge Congress and the Administration to work together to remove the roadblocks to the funding of current programs, to move forward with expanded initiatives, and to create new payment structures for services through existing federal health insurance programs. More funds should also be allocated for research initiatives in the areas of prevention, diagnosis, treatment and treatment outcome assessment. Congress should explore cooperative efforts designed to streamline the treatment system, coordinate care and improve case management.

In addition, special efforts must be made to reduce the waiting lists for treatment. It is estimated that there are approximately 35,000 people who will be unable to get treatment slots in major U.S. cities and that anywhere between 40% to 90% of all people voluntarily seeking treatment are turned away each year. New, expanded programs are to ensure the inclusion of those seeking treatment such as programs designed to provide pretreatment services including where appropriate, diagnosis and some form of counseling or therapy.

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MENT PROGRAMS TO MEET SPECIAL NEEDS: Some populations are from established forms of treatment programs and have special be taken into consideration. Children, for example, may not traditionally adult models of treatment; women of child- special educational efforts aimed at prenatal care and for their children. Policymakers must guard against viewing id models and must support development of policies that allow opportunity to acess flexible, multifaceted programs.

4. IMPR
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ABUSE EDUCATION THROUGHOUT EDUCATIONAL AND SOCIAL PROGRAMS: begins in the home, schools and in the community. We need each to populations at risk and to provide education for the on about the dangers of drug abuse. It is critical that these misconceptions about drug abuse (see previous discussion ture of crack/cocaine addiction). These efforts should also vercoming the barriers, misconceptions and biases that add to ance to treatment centers.

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RANCE BENEFITS FOR TREATMENT: Insurance companies and self- s should be required to provide or make available coverage for ment. Currently thirty-eight (38) states and the District of that private health insurers either cover or offer coverage reatment services. Twenty-one (21) states and the District of date the coverage of or the offering of drug dependency e benefits.

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R INVOLVEMENT IN DRUG ABUSE DETECTION AND TREATMENT: Employers aged to take more responsibility in the detection and stance abuse problems among their employees through mechanisms ntives, public/private partnerships and other methods. be encouraged to establish employee assistance plans (EAPs) r drug and alcohol education, early intervention and treatment e options for outpatient as well as inpatient care. Only 25% workers are currently covered 989).

9. BE
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DINATION BETWEEN DRUG ABUSE TREATMENT FACILITIES AND CARE SYSTEMS: Drug treatment programs are often run as e from other local heath care facilities. This creates an of health care services, increases costs and creates ma. Drug abuse officials should work with the f existing health care and mental health care systems to fforts to lower costs, share resources and improve the ices for treating drug dependency.

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